

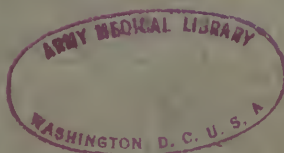
REPORT OF THE
MEDICAL OFFICER
NEW YORK CITY HEADQUARTERS
SELECTIVE SERVICE SYSTEM

October 15, 1940 to May 8, 1945 (V-E Day)

Asst. Military Surgeon, U.S.

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U.S. SELECTIVE SERVICE SYSTEM. New York (City)

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PREFACE

This report comprises the activities of the Medical Division from the commencement of Selective Service to V-E Day, May 8, 1945.

The Medical Officer is assigned to a State Headquarters with Regulations outlining the duties of Local Board Examining Physicians, Medical Advisory Board doctors, and dentists. These Regulations and directives are specific as to the duties of these groups of medical professional personnel.

The Regulations as to the specific duties of the Medical Officer are exceedingly meager. Hence it was obvious that he had to devise methods to set into operation a uniform set of procedures as to the duties of the professional staff, all of whom were volunteers working without pay, but it was also necessary for him to improvise and develop his own field of work in regard to the responsibilities of his office, along such lines as the local situation in the area under the jurisdiction of the Headquarters to which he is assigned indicated as necessary. The ensuing pages will give an outline as to how these situations were found, met, and generally handled in the New York City area.

In the work of the Medical Division, innumerable conferences and coordinated endeavors often became necessary between the Medical Officer and the Operations, the Legal, the Inspection, and the Occupational Divisions. The excellent cooperation and helpfulness always extended to the Medical Officer are gratefully acknowledged. To a large extent, whatever success has accrued to the Medical Officer in his tasks is in no small measure to be traced to the fine cooperative spirit extended by the commissioned officers handling these divisions.

National Headquarters, too, in its various divisions has given inspiring direction. We in the New York City area have been most fortunate in the personality of the Regional representative of National Headquarters, Captain Ernest B. Erickson, USNR, who by his comprehension of the complexity of the problems inherent to a city like New York has been an unfailing source of helpful advice and counsel. We acknowledge our indebtedness to him in being mutually helpful in clarifying many difficult situations.

To the paid clerical staffs also must go credit for their fine contributions toward coordinated cooperation. To the paid staff, and the staff of volunteer physicians working in the Medical Division, sincere thanks are also due. In their devotion to their jobs - particularly the Medical Division paid staff - they often worked at a pace and in length of hours beyond what in ordinary times would have been considered the "wonted activities" of such jobs. They did this and stayed on their jobs despite pay-schedules less than any one of them could have earned in outside jobs.

This picture, which I am endeavoring to describe in a few paragraphs, of devotion to assigned duties by commissioned officers assigned to a civilian agency far separated from the dramatics of war front service with its essential high level of morale and indoctrination in the effective spirit of coordinated team work, is without question due to the wise judgments, good counsel, and fine support the Medical Division has enjoyed at the hands of Colonel Arthur V. McDermott, the New York City Director. I can say without mental reservation that most of the varied and extended activities reported herein, most of which have had favorable receptions from the general medical profession of the city, from the colleges, and from the hospitals can be traced to the inspiring leadership of the New York City Director. I freely acknowledge my indebtedness to him for the privilege I have enjoyed in serving in the capacity of Medical Officer to his Headquarters, and the support I have had from him in various of our endeavors which were improvised because they were not specifically covered in current regulations or directives.

May 8, 1945.

Samuel J. Kopetzky
Colonel, MC
Medical Officer, N. Y. City Headquarters
Selective Service System

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October, 1940 to V-E Day, May, 1945

GENERAL BACKGROUND

The New York City area over which this Headquarters exercises jurisdiction has inherent differences from that of any other State Headquarters.

All our registrants are within a five cent fare trip of the Headquarters. The City has an ample supply of medical facilities within easy reach of every registrant's home. There are approximately 16,580 practicing physicians in the City. There are five Grade A Colleges of Medicine, two Colleges of Dentistry, and four Colleges of Pharmacy, and one hundred forty-six hospitals in the city.

The population of the City comprises many foreign language groups consisting of many nationalities. Of a total population of 7,454,995 in New York City, on April 1, 1940 2,080,020 were classified by the U. S. Census as "white - foreign born." Of these, 62.4% were counted as naturalized citizens. (Report by J. C. Capt, Director, Bureau of the Census). This background must be kept in mind when noting the problems, many of which are peculiar to the city and its population, which came before this Headquarters for clarification and decision.

INTRODUCTION

This report comprises the organization of the Medical Division and the types of its functions since the commencement of Selective Service activities to May 8, 1945, V-E Day.

In outline, it is a chronological record of Local Board physical examinations, Medical Advisory Board functions, and medical matters pertaining to the procurement of manpower for the military forces, including review of all DSS Forms 200 and DSS Forms 221 to rectify clerical and other errors in classification based on medical reasons.

It also outlines the medical aspects of procuring for the Armed Forces medical, dental, and veterinary officer personnel, in cooperation with the New York State Procurement and Assignment Service. On the one hand, the need of the Armed Forces for their professional personnel and on the other, care not to deplete the civilian medical facilities of the City all come into focus when considering the individual status.

There also came under the consideration of this Division certain professionals whose individual status needed study and report. These included registered pharmacists, registered male nurses, technical help on hospital staffs, embalmers and morticians, and medical, dental, and veterinary pre-professional and professional college students.

The claims of dependents of registrants who alleged ailments and diseases which precluded them from engaging in gainful occupations to support themselves or the remainder of the registrants' families, brought most of the certificates of their physicians regarding their physical disabilities to this Division for investigation, report, and decision.

Finally, when men discharged from military service with honorable discharges alleged recovery from the disability which caused their separation from the service, who thereupon volunteered for re-entry into the Armed Forces, it required that their disabilities be studied and if the situation which caused their separation from the service was corrected or the disease cured it was necessary to institute steps to permit them to return to military duty of their own free will. Other discharged servicemen were routed to agencies and facilities where therapeutic measures which they needed were placed at their service.

In addition to the above, from time to time various studies and reports were made by this Division and forwarded to appropriate sections of National Selective Service Headquarters. These are listed and outlined herein.

THE PHYSICAL EXAMINATION OF REGISTRANTS

Some time before Selective Service became activated the Medical Societies of the five counties of New York began to nominate doctors to serve on the Medical Advisory Boards and as Local Board Examining Physicians. Twenty-six Medical Advisory Boards were formulated and activated throughout the City. Each consisted of at least one of the following specialists in medicine: otolaryngologist, ophthalmologist, internist, orthopedist, neuropsychiatrist, roentgenologist, surgeon, and dentist. Later, as the need arose, dermatologists and urologists were added to the Medical Advisory Boards. As the burden of work became heavier and the need was shown, additional specialists were nominated to each Medical Advisory Board, and in some cases as many as four of each specified type of specialty were represented on the Medical Advisory Board.

The Local Board Physician

Two physicians were nominated to serve on each Local Board. The Local Board physicians examined registrants in accordance with criteria and standards outlined in Volume No. 6 of Selective Service Regulations.¹ It was entirely within the jurisdiction and judgment of the Local Board physician to qualify a registrant for general military service or limited service, or totally to reject him for either. At that time the examination given by the Local Board physician was complete, including a urinalysis. The examinations were made at the quarters of the Local Board.

It is to be remembered that the Local Board physician was not a member of the Local Board but was attached to the Medical Division and served as medical advisor to the Board in his specific capacity to examine the registrants and make notations as to acceptability or disqualification.

How Physicians Were Selected ²

Arrangements had been made with the local County Societies to take the responsibility of making nominations of qualified men for all these positions. The local County Medical Societies of the five Counties also had agreed that in view of a complaint of any irregularity of conduct on the part of any of the physicians necessary disciplinary action would be taken by the Board of Censors of their County Society. It is with some pride that we can announce at the end of four years of service that no single case of disciplinary action has been found necessary.

¹ Volume No. 6, Selective Service regulations laid down the standards for acceptance for full or for limited military service and for rejections.

² During the period herein reported, there have been 2,141 physicians serving as Local Board Examining Physicians and 436 on Medical Advisory Boards. 413 dentists served our Local Boards, and 21 served on the Medical Advisory Boards

PROCEDURES OF THE LOCAL BOARD PHYSICIAN
IN RELATION TO THE MEDICAL ADVISORY BOARD

Where the Local Board physician had doubt regarding the diagnosis of a condition which a registrant presented or where he deemed it necessary that laboratory tests and procedures be undertaken before it was possible to make a determination, the Local Board physician at that time referred the registrant to the Medical Advisory Board for further examination and for the necessary laboratory procedures. In addition, if the registrant did not feel that he had been properly and correctly rejected or accepted by the Local Board doctor, he had at that time the right to take an appeal on the physical findings. He was then sent to the specialist concerned with the type of disability which he was alleged to have for an independent examination and a specialist's opinion and decision.

The Medical Advisory Boards at that time were, under our Regulations, permitted to do any laboratory tests they thought necessary at rates to be charged to the Government, in accordance with a fee schedule drawn up by National Headquarters. In this area this fee schedule was recommended to National Headquarters by me based upon the fee schedule in force in the State of New York under the Workmen's Compensation Law. In determining the different rates to be paid for the laboratory procedures this fee schedule received the approval of the hospitals and it was so administered that the fee merely covered the cost of the materials and did not include the service of the doctor. All medical or dental personnel serving Selective Service did so as a patriotic contribution to the war effort and not for fees.

Each Medical Advisory Board had one of its members nominated as the Chairman and he was permitted part-time secretarial help, which was paid for. It was the duty of the Medical Advisory Board Chairman to see that the various cases were allotted to the proper specialists and to make sure that the reports were returned to the Local Board, and the bills certified and sent to this Headquarters for processing for payment.

In March, 1941 the work of the Medical Advisory Boards became so heavy due to appeals and the increase in quota calls that the Medical Advisory Board Chairmen were advised to duplicate specialists on their staff in order to facilitate the work. This was done with the cooperation of the five County Medical Societies.

I have already alluded to the fact that the registrants were allowed to take an appeal from the medical findings of the Local Board Examining Physicians. This necessitated that their cases be sent to the Medical Advisory Board and the registrants be examined by the Medical Advisory Board for the determination of the questions under dispute. While this procedure was in vogue the registrants continued telephoning to the various Medical Advisory Board doctors to discover the results of their determination. The Local Board doctors were therefore advised not to give any information to the registrants but to make a report only to the Local Boards, and to advise registrants to apply to their Local Boards for information as to their status. It soon became apparent that any registrant who felt like it could appeal from the medical findings and that the procedure was too unwieldy. Regulations thereupon were amended and no further appeals on medical grounds were permitted. The findings of the Local Board physician or, as the case might necessitate, of the Medical Advisory Board physicians were final.

In April, 1941 the Local Board Examining Physicians were doing complete physical examinations but, there having been a liberalization of the standards regarding teeth, it became necessary to assign two dentists to each Local Board. The First and Second District Branches of the American Dental Association nominated competent men to serve in this capacity.

In June, 1941 it was determined that Medical Identification cards were to be distributed to the Local Boards. These cards were for the purpose of ascertaining whether the registrant had at any time had a history of a mental illness. The Local Board clerks filled out the card with the registrant's name, address, age, and names of relatives and Local Board numbers. They were sent to the New York State Department of Mental Hygiene in Albany for a check through their central file to determine whether or not the registrant had at any time had a commitment to a mental institution in the State of New York. These cards were returned to the Local Board with a notation "Not Identified" or, there being a record of commitment to

some institution, the name of the institution was given. The cards of registrants who showed that they had a record of hospitalization or institutionalization were then forwarded to the Medical Advisory Board psychiatrist, who made an inquiry direct to the institution concerned for the purpose of obtaining details regarding the commitment, namely, the diagnosis and prognosis. On the basis of this report the psychiatrist would make a recommendation to the Local Board as to whether the registrant should be rejected at Local Board level or whether he should be submitted to the psychiatrist for further psychiatric examination. In cases where a registrant was examined by a psychiatrist, the psychiatrist would naturally make a recommendation to the Local Board - either of rejection or of the registrant's being qualified for military service.

The assignment of psychiatrists and the procedures in regard to the processing of Medical Identification Card #1 and also the work of the psychiatrist was devised and worked out by the New York City Medical Division in conjunction with the New York City and New York State Committee on Mental Hygiene.

Test In Rehabilitation

About July, 1941 a test in rehabilitation was undertaken in New York City. The North Atlantic District Branch of the American Association of Medical Social Workers volunteered their assistance and the Local Board Examining Physicians and the Medical Advisory Board doctors were apprised of the program, which consisted in having the Local Board go over the records of such cases as the medical social worker would consider as remediable. Through contact with the registrant or his family they were to endeavor to persuade him to go to one or other of the hospitals or other facilities where remedial therapy might be obtained. Miss Sadie Shapiro was assigned to supervise the work, and a secretary was assigned to her, paid for by her organization. These two social workers were given desk space at this Headquarters.

I cannot say too much in praise of these social workers, who made contacts with private practicing physicians, dentists, clinics, hospitals, and Board of Health Stations in the interest of the registrants, and who followed up the cases, as much as it was possible. All personnel, with the exception of the secretary, did this work on a voluntary basis after their regular working hours. Through this program 3,996 registrants were referred for rehabilitation on a voluntary basis. There were 9,634 registrants interviewed because the nature of their disability made it appear likely that remedial therapy would be helpful in giving them at least a better health level in their civilian occupations if it failed to make them fit for limited or general military service.

Arrangements had been made so that none should fail to receive medical care, if they accepted it, because of financial inability to pay for it. Both the medical profession and the hospitals were cooperating wholeheartedly to make the volunteer rehabilitation program a success.

The nature of the referrals is pertinent. Thus, 1,020 were referred to medical clinics. 159 were sent to dental clinics. It was found that an additional 562 were already being treated in medical clinics and 21 were likewise being treated in dental clinics. The interviews with the rejected registrants further evidenced that 1,602 were under the care of their private physicians and 340 were under the care of their private dentists. The interviews demonstrated that of the 9,634 interviewed, only 507 reported that they could not afford to pay anything for medical care, and it developed that of these 396 were handicapped in paying for artificial teeth replacements, dental bridges, and dental plates.

At the completion of the period of this test on rehabilitation it was found that 1,014 had attained the maximum recovery attainable. In 823 the condition was stationary, and in 191 the condition had been corrected, even before interview by the social worker.

There were 1,230 who refused to sign the necessary waivers so that the social worker could study their physical examination records. In addition, 308, although they permitted study of the type of their disability, absolutely refused to have anything done about it.

This program was a worthwhile endeavor. It proved that a rehabilitation program was feasible. Major surgery was done without untoward incident. Obviously, there was no authority to compel acceptance of remedial therapy. I asked for such authority because in war time I could not accept the condition that a man of military age could shield himself

behind a remediable physical defect for which medicine or surgery held a cure, to avoid his military obligation as a citizen. Such authority, however, was never given and the project was dropped.

In the cases of registrants rejected for tuberculosis, the names of such were forwarded to the Bureau of Tuberculosis, New York City Department of Health. This was for the purpose of checking the reason for rejection and also to see that registrants in the infectious stage of this disease came under treatment. This action was in compliance and in accordance with the New York City Sanitary Code. Often, registrants did not respond to correspondence from the Chest Clinics and in such cases their names were given to the Local Board so that the Local Board could see to it that the registrant appeared at the Chest Clinic for further examination. This procedure started in July, 1941 and is still going on in the interest of the registrants' families to prevent them from being unduly exposed to tuberculosis, and also in the interest of the registrants themselves, who might otherwise not have come under treatment. Many of these men first found out they had a tubercular lesion in their chests when they were X-rayed either at the Local Board level or at the Armed Forces Induction Station examination.

The question of venereal disease concerned us from the beginning. These men at that time were not accepted for duty with the Army. It disturbed me very much that these men should be allowed at large with an infectious venereal disease so in August, 1941 through contact with the Bureau of Social Hygiene of the New York City Department of Health, each Local Board received a Directory of Venereal Disease Clinics. Moral suasion was exercised by the Boards so as to refer registrants rejected for venereal disease to the clinic nearest their residence.

In September, 1941 National Headquarters revised the fee schedule for laboratory and medical work, and this was transmitted to all Local Boards in the City.

Up to September, 1941 the result of the determination on physical examination was noted on a DSS Form 200, which Form carried the registrant's signature. However, when a registrant was referred to the Medical Advisory Board for a detailed specialist's examination, occasionally a different person would appear for this examination since the registrant was not known to the Medical Advisory Board doctor. In order to avoid substitutions, the Medical Advisory Board doctors were directed to have the registrants sign their names before them when they appeared for examination and the signature could be compared with the one already before the doctor on the Form 200.

At this time the Local Board Examining Physicians were instructed to add the letter "R" following their recommendations for classifying men in IV-F or I-B when in their medical opinion the registrant could be put in a higher classification if the deficiency found at examination were corrected by curative therapy, medical, surgical, or dental. This was done to help the volunteer rehabilitation program put in progress in this area.

In November, 1941 National Headquarters advised that a change in procedures in regard to medical examinations was to be put in effect in January, 1942. The new procedure provided for a complete and thorough examination of the registrants at the Armed Forces Induction Station. The Local Board Examining Physicians would merely do a screening procedure, weeding out registrants with obvious defects. These obvious defects were listed in DSS Form 220. At that time it was further determined that a change in regard to Medical Advisory Board physicians should take place, namely, that no case should be referred to the Medical Advisory Board physician prior to the examination at the Induction Station, and all laboratory examinations were to be stopped in the New York City area. When any doubt existed as to a case, the man was to be referred to the Armed Forces Induction Station for determination. After January, 1942 registrants were sent to the Armed Forces Induction Station for a pre-induction examination, and if they were found acceptable for either general or limited service their induction took place from twenty to thirty days later. At this time the right to appeal physical findings was also dropped.

Effective January 1, 1942 the criteria for examinations at Local Board level were revised. Local Board Release No. 66 became the standard for determining physical fitness at Local Board level. This Release consisted of Part I and Part II. Part I consisted of a list of physical defects which disqualified registrants for either general or limited service. Part II consisted of a list of defects which disqualified registrants for general service but qualified them for limited service.

The examinations of the physicians at the Local Board level now became "screening" examinations to determine whether a registrant had any of the physical defects listed in either Part I or Part II of Local Board Release No. 66, and there were no laboratory procedures required or permitted. When there was any doubt as to a determination or where laboratory procedures were necessary, the registrants were forwarded to the Armed Forces Induction Station for processing.

Up to this time, the blood for serological examinations was taken by the Local Board physicians. In order that the reports from the blood examinations should be returned in time, the examinations were usually held during the evening hours. At the completion of the examination one of the team would take the serological to the nearest Police Station and, an arrangement having been made with the Commissioner of Police, the Board of Health Collecting Service would bring the specimen to the Board of Health laboratory the same evening, and within five days the report would be back at the Local Board. Selective Service is greatly indebted to the assistance which it received from the Police Department in this effort.

The new procedure under Local Board Release No. 66 eliminated the taking of serologicals by the Local Board Examining Physicians because the registrants, under the new procedure, would be given a blood test at the Armed Forces Induction Station and if it was found to be doubtful or positive the Local Board physicians would then only take an additional serological because two tests were necessary.

The Report of Physical Examination and Induction was also revised so that the Local Board Examining Physician, after the registrant's screening, could answer the following two questions with either a "yes" or a "no":

"Do you find that the above named registrant has any of the defects shown on Part I of the List of Defects (Form 220)? (If in doubt answer "no")."

and

"Do you find that the above named registrant has any of the defects shown on Part II of the List of Defects (Form 220)? (If in doubt answer "no")."

As you can see this tended to lessen the work of the Local Board Examining Physician.

The Medical Advisory Boards also found that their work was reduced to a minimum and they were advised to discharge their clerical help. Nevertheless, some Medical Advisory Boards were still in use to clear up doubtful cases after Induction Station examinations. Laboratory procedures were still kept at a very minimum.

Quotas were becoming larger each month and it was anticipated that in spite of the lessened burden on the Local Board Examining Physicians because of these increasing quota calls the work was still too burdensome for Local Board physicians to handle. Therefore, they were advised that if at any time they felt they could not keep up with the numbers of examinations required of them they were to notify immediately this Division and additional physicians would be assigned to the Local Boards to cover this emergency. For this emergency several teams of doctors were formed, to be ready at a moment's notice to go to any Local Board in the City to make the required examinations. Fine cooperation was received both from the doctors and from the five County Medical Societies to carry out this idea.

The Local Boards were advised that in the case of any registrants rejected with remediable defects the classification was to be I-A-R. The Examining Physicians were advised to mark on the Form 200 any information available regarding the registrant's mental condition and if in need of additional information, to write to the New York City Committee on Mental Hygiene.

For the month of January, 1942 and the month of February, 1942, as previously stated, the Induction Station took the serologicals. However, it was found that with the increasing quotas, the facilities at the Induction Station were not adequate. Therefore, the Local Board Examining Physicians were advised that as of March 14, 1942 they would again be required to take serologicals.

In March, 1942 the system of examination was again revised, eliminating the pre-induction examination. This also called for the taking of serologicals by the Local Board Examining Physicians for all registrants to report for induction in March. Since at this time the quotas were high, the burden on the Examining Physicians was very heavy, for they

had to complete examinations for registrants scheduled for induction in April, and in addition take serologicals on the registrants for induction in April and those to go in March. In order to assist the Examining Physicians in this emergency, arrangements were made with the Department of Health local Clinics to take serologicals of registrants from Local Boards all over the City, where the Examining Physicians were unable to keep up with the quotas. Arrangements were made through this Division on receipt of a call from a Local Board.

Preparations To Undertake Remedial Therapy On National Level

At this time it was decided by National Headquarters that a Rehabilitation Program would be put into effect, making use of the Examining Physicians and dentists of the Local Boards. The first step was to establish a national roster of physicians and dentists who were to do the work. To accomplish this, application forms were sent to all the Examining Physicians and dentists assigned to the Local Boards to be filled out. The rehabilitation was to be done at a fixed rate according to a fee schedule to be published later. After the Examining Physicians and dentists assigned to Local Boards had applied, other doctors and dentists were to be permitted to do so. However, the collecting of applications was as far as this project ever went. The Selective Service System had made a decision that it did not want to be involved in a system of remedial medicine. After four years, because of the needs which predicate the call quotas for manpower for the Armed Forces and the stress in war industries for manpower, the question of instituting a system of surgical and medical therapeutical procedures under the supervision and control of the Selective Service System is again being considered. It seems doubtful that it will be undertaken. Were it undertaken, it is also doubtful that much manpower would be salvaged.

Since the preinduction examination was eliminated, it became necessary for the Local Boards, with the aid of the Examining Physicians, to procure all evidence as to medical and mental conditions, so that this might be sent to the Induction Station for consideration. The information procured was insufficient regarding mental conditions, and therefore in May of 1942, in order to lessen the induction of psychiatric cases it became necessary to institute the following procedure: a social psychiatric worker was assigned to each group of ten or so Local Boards, approximating the grouping of the Local Boards coming under the jurisdiction of the Medical Advisory Board. Additional psychiatrists were assigned to each group of Local Boards. The Local Board Examining Physicians were instructed to have a brief, adequate conversation with all registrants in an endeavor to discover any suspicion of psychoneurosis, mental deficiencies, epilepsy, history of commitment or other mental or emotional conditions which would make a registrant unfit for Army duty.

Registrants coming under the above outlined categories would then be referred to a psychiatric social worker who would take a history of the men referred to her. The report of the psychiatric social worker was then to be transmitted to the Local Board, who would turn it over to the Examining Physician. The Examining Physician would abstract it and put a summation on the Form 200 for the information of the Army Induction Examining Team. In cases where an actual examination by the psychiatrist would be deemed necessary, arrangements would be made for such an examination.

In May 1942, National Headquarters advised that all registrants who were discharged from the Armed Forces prior to December 8, 1941 for physical disabilities could be re-processed for induction, and the Local Boards were accordingly advised.

In June, 1942 National Headquarters ruled that registrants should not undergo an interview by the psychiatric social worker before going for induction but that any information available should be noted on the Report of Physical Examination. However, the psychiatric social workers were still to aid the Local Boards in procuring such information.

Up to September, 1942 the quota calls kept steadily increasing so that it became evident that something would have to be done to facilitate the examination of the registrants. Aside from the fact that the doctors could not handle the required examinations because of time, the problem of space in the Local Board quarters came into the picture. The result was that "Examining Teams" were formed.

Hospital Examining Teams

These Examining Teams served on an average of about six Boards each, and they held examinations about twice a week. These teams were composed of approximately thirty doctors each, and there were fifty-two such teams formed throughout New York City. One of the doctors on each team was designated as the Chief of the Team to coordinate the work, and in addition there was appointed a Supervisor over these teams, in each borough of the City. It was the duty of the borough Supervisor to straighten out any difficulties the individual teams might encounter, make arrangements for locations, set up the procedure to be followed in examining, and arrange for the dates of examination.

In Brooklyn, where it was particularly difficult to set up these teams because of the distances involved and the inconvenience in travelling for both the registrants and the doctors, it became necessary to set up a separate team for the purpose of absorbing the overflow that the other Brooklyn teams were unable to handle. This team consisted of about fifty doctors and they functioned once a week.

The large numbers of registrants to be examined by these teams brought up the problem of proper locations. For this purpose most of the city's hospitals offered their space and facilities. In some instances they donated their personnel also to assist in handling clerical detail, drawing blood, and doing other services for the examining doctors. In addition, a number of private hospitals did the same thing. For other locations it was necessary to call upon private companies and schools to secure space. In these cases, lay persons volunteered to assist the doctors with all the many details involved with this work.

At the inception of this change all sorts of different problems arose. For one thing, as is usually the case with a new project, there were protests from some of the doctors that it couldn't be done and wouldn't work. However, as soon as the first team was set up properly and the protesting doctors saw how they worked, these protests were silenced. These same doctors then did all in their power to set up teams themselves that were as efficient and ran as smoothly as the model team, and they took great pride in their achievement. These doctors did all this examining without any remuneration whatsoever, taking precious time from their own very busy schedules, and paying their own expenses insofar as travelling, telephones, and other incidentals were concerned.

The maintenance of order at these hospital stations was a voluntary contribution by various Posts of the American Legion. These Legion Posts sent men in their Legion uniforms to help in clerical work, keep order, and be generally helpful. The USAAC organization of veterans of World War I, an organization which manned ambulances in France during the prior World War, also engaged voluntarily in this duty. Both the Legion and the USAAC thus made noteworthy contributions to the war effort, because this was a continuing service and took the leisure time of men engaged in their wonted occupations, after the day's work. All these teams worked evenings.

The quotas kept steadily increasing at this time, until March of 1943, and the strain upon all these people was tremendous.

These examinations were mostly done at night. Naturally, there were occasions where registrants who did night work or theatrical work found it involved quite a loss for them to be examined at night. When these cases were brought to the attention of this Headquarters, special arrangements were made with individual doctors at their offices for the examination of these registrants, and, of course, there were always a few volunteer doctors on hand at this Headquarters to jump in and pinch-hit. All in all these large scale examinations which taxed the capacity of everyone involved, brought out hidden talents, ingeniousness, and limitless patience. The team examinations were a great success.

The Psychiatric Advisory Committee

In the early part of 1942, because of the multiple problems concerned with psychiatric questions, there was set up in this area a Psychiatric Advisory Committee. The Committee consisted of the following:

Dr. Richard Brickner, Chairman
Dr. Marion E. Kenworthy
Dr. Lawrence S. Kubie
Dr. Robert W. Laidlaw
Dr. Lawson G. Lowrey
Dr. John Alfred P. Millet
Miss Marian McBee
Dr. George S. Stevenson

Miss McBee and Dr. George S. Stevenson were from the National Committee on Mental Hygiene.

This Committee met at frequent intervals, and discussed and advised on current problems as they arose. The Committee was largely instrumental in creating the favorable attitude among lay psychiatric social agencies and workers which resulted in recruiting the large force of psychiatric social workers who joined our staff of voluntary help and accepted the assignments as Medical Field Agents to our Local Boards.

I freely acknowledge indebtedness to this group whose contribution to the war effort has been noteworthy. To them, and to Mrs. Ethel Ginsburg, who organized the original group of Medical Field Agents, we are deeply indebted.

Sex Variants

Those psychopaths who tell either Local Board officials or the medical examining physicians stories of psychosexual conditions, were for a time a problem at this Headquarters. Sex perversion is a legitimate cause for disqualifying a registrant at the Local Board level. Once the story spread through a given neighborhood that if the registrant told the doctor a story implying sexual perversion he was disqualified, the numbers of such began to increase. The news soon spread that a confession of disinclination for normal, and a habit of abnormal sex relationships would disqualify a registrant at the Induction Station. Here, too, the numbers of such rejections began to increase. Anonymous letters began arriving telling of boasts made of how easy it was to avoid military service by telling "tall tales" to the examining physicians.

Therefore, arrangements were made with Professor George Henry, an outstanding authority on sex variants, to undertake the clarification of this problem. He set up a clinic for the examination of such cases at his department at the New York Hospital - Cornell Medical Centre. All registrants claiming sex variations were referred to him for psychiatric examination, opinion, and report. At his clinic there exists a file of many thousands of names of such unfortunates. The confessed sex variant established his contact, whose name often was on record. Professor Henry's reports came to this Headquarters, and were routed from here to the Local Board for their information and guidance in classifying the registrant.

Once this system became established, the "tall tales" ceased, and the numbers appreciably dropped, and there only remained the disclosure of legitimate cases of sex variants who thus were properly disqualified for military service.

In the course of the work, the problem becoming less acute, the Psychiatric Advisory Committee to the Medical Division made representations to the Medical Division that they believed all the neuropsychiatrists on our staff should take part in this work. They stressed that any qualified psychiatrist was able to detect false claims of sex variations, and could diagnose correctly this condition. Furthermore, they pointed out certain conditions existing on Professor Henry's staff, which unfavorably affected these sickened individuals. Without entering into any partisan discussion of these issues, and to relieve the heavy burden which Professor Henry had carried almost alone for two years, last Spring the procedures were modified and the affected registrants were sent to the neuropsychiatrists on our panel for examination and opinion. The present procedure is working well.

Psychiatric Screening Under Medical Circular No. 4

There had been a test of psychiatric screening going on at this Headquarters for almost a year before Medical Circular No. 4 was issued by National Headquarters. Its

importance and the information received had demonstrated the great usefulness of the procedure. This test was performed entirely upon a voluntary basis, and field workers, the New York Social Service Exchange, doctors, and institutions all cheerfully cooperated. Being upon a voluntary basis, the numbers investigated were not large. Only names regarding which the officials of Local Boards, or the Examining Physicians of these Boards, had reasons to make inquiry were submitted to the procedures evolved by the Medical Officer of this Headquarters.

On October 18, 1943 Medical Circular No. 4 was issued by National Headquarters. This Circular concerned what it described as a "Medical Survey." It changed the designation of the social and psychiatric social volunteer workers to that of Medical Field Agents. It covered a rather broad and comprehensive program under which information concerning registrants is gathered for transmittal to the Medical Officers of the Armed Forces Induction Stations for use in making determinations as to acceptance or non-acceptance for military service.

About the beginning of January, 1943 definite plans were under way for what is now known as the Medical Survey Program. In New York City, the New York City Committee on Mental Hygiene was the organizing factor and paid for the services of Mrs. Ethel Ginsburg to head the program at this Headquarters, and two secretary-stenographers, and also assigned this personnel to Selective Service. At the same time, arrangements were made with the numerous social welfare agencies in the City, both private and governmental, for the purpose of their submitting information regarding registrants, upon inquiry from this Headquarters.

These social workers, having been recruited, were asked to take a course of six lectures arranged by this Headquarters to be given them by Dr. S. Mouchly Small, one of the psychiatric staff of the New York Hospital. These lectures were subsequently published.³ The prospective Medical Field Agents were thus indoctrinated as to their duties and responsibilities. It was stressed to them in their lecture series to approach all their problems anent Selective Service objectively and dispassionately. They were taught to avoid any tendency toward the adoption of a protective role when interviewing or contacting families under Medical Circular No. 4 procedures.

At the same time the work began of assigning social psychiatric workers to each Local Board. Since all the social welfare agencies were aware of this program the response among the psychiatric social workers for volunteer work was very gratifying. At the beginning of this program the Local Boards were instructed to refer to these social psychiatric workers any registrant who seemed to present a special problem with regard to dependency questions, etc., or who had a history of hospitalization or commitment, or any registrant who gave any indication of not being normal.

It was the aim of this program to have every registrant interviewed by a psychiatric social worker before he went to the Induction Station. However, in view of the particularly high quotas at this time, and the fact that the program was just being established, it was impossible to do more than stated above. Each case referred to a psychiatric social worker took a great deal of time for it necessitated, first of all, an interview with the registrant which lasted from half an hour to over an hour. After that, the psychiatric social worker would have to write to any of the doctors the registrant might have mentioned and to any of the institutions mentioned and wait for the information to be returned before she could begin to make her report. In dependency cases, she sometimes would find it necessary to interview the family of the registrant.

The work at this Headquarters with regard to this program grew in leaps and bounds and it became necessary for the New York City Committee on Mental Hygiene to assign several part-time psychiatric social workers at this Headquarters, to assist Mrs. Ginsburg. Since this Headquarters was not quite prepared for the volume of work that would be entailed and the number of people necessary, there was not sufficient space nor equipment to meet the needs of this program. However, as quickly as it could be secured, additional equipment was had and additional space secured.

The Local Boards, as can well be appreciated, were not too happy about this program

3 "Symptoms of Personality Disorders" - Prepared for the use of Medical Field Agents in Selective Service Screening - by S. Mouchly Small, M. D. - Published by the Family Welfare Association of America, 122 East 22 Street, New York City, N. Y.

for it only meant additional effort on their parts at a time when the quotas were increasing so steadily as to make it almost impossible for them to meet the demands. However, notwithstanding some "griping" here and there, after they once realized the importance and the scope of the program, they became very interested and put all their resources at the disposal of this program. Local Boards had to remain open an extra night a week in order to arrange for the interviewing to be done by the psychiatric social workers who did all this work, voluntarily, after their regular working hours. This program has resulted in keeping many misfits out of the Army and thus saving the many millions of dollars which would be necessary to discharge these men - not to mention the pensions that were saved.

Medical Survey Program Procedure

Forms 210 are sent in by the Local Boards on all registrants being processed for induction. Forms 211 are sent in only on registrants who have attended secondary school within the preceding five years of the time when the registrant is being processed for induction.

The Forms 210 are checked against the Bellevue-Kings County file at this Headquarters. If any of the registrants for whom a Form 210 has been submitted is positively identified, after checking with the Bellevue-Kings County file, as having a defect listed in the DSS Form 220, the Forms 210 for those registrants are immediately returned to the Local Boards with a covering letter, advising the Local Boards to classify the registrants in IV-F at the Local Board level.

The remaining Forms 210, for which there was no record in the Bellevue-Kings County file, or where the identification is questionable, are sent to the Social Service Exchange for clearance.

When the Forms 210 are returned by Social Service Exchange, those identified and those not identified are separated. On those identified, form letters are sent to the agencies, courts and hospitals listed by Social Service Exchange, for more detailed information.

Where the Local Boards have Medical Field Agents, the Forms 210 are immediately returned to the Local Boards after the letters have been sent out to the agencies. In these cases, an envelope addressed to the Medical Field Agent is included so that the agency reports are returned directly to the Medical Field Agents by the agencies.

In cases where there are no Medical Field Agents at the Local Boards, the Forms 210 are held at this Headquarters and letters to the agencies, requesting information, are sent out with return envelopes addressed to Mrs. Daniels, who is the Medical Field Agent acting as advisor to the Medical Survey Program at this Headquarters.

When the Medical Field Agents receive the reports from the agencies, if there is pertinent information, they interview the registrant and make out a Form 212.

In the cases where there are no Medical Field Agents at the Local Boards and the reports are returned to this Headquarters, on receipt of the reports at this Headquarters, appointments are made for registrants on whom pertinent information has been secured. The registrants are interviewed at this Headquarters by a special group of Medical Field Agents who meet on Tuesday nights, Forms 212 are made out and then the Forms 210 and 212 are returned to the Local Boards in a Form 212-A.

On Forms 210 not identified, if an out of town address is given, this Headquarters writes to the out of town Headquarters covering that address for information regarding the registrant. In addition, if the registrant has made any statement on the Form 210 or Form 211 which would indicate further study, the case is called to the attention of the Medical Field Agent by marking the Form 210 "Refer to Medical Field Agent" and returning it to the Local Board with a referral letter to the Medical Field Agent.

Every year the secondary schools send to this Headquarters Forms 213 covering all students who have enrolled, ages 17 to 18.

The Forms 211 are checked against our file of Forms 213 and if a Form 213 is found to correspond to the Form 211, it is stapled to the Form 211 and both Forms are returned to the Local Board.

If no Form 213 is found and the registrant has been in a secondary school within the past five years, a Form 214 is sent to the last school mentioned, to be filled out. When the

Form 214 is returned, it is sent to the Local Board where it is examined by the Medical Field Agent for any possible clues as to pertinent information.

The Local Boards send down to the Induction Station any Forms 210, 211, 212, 213, or 214 they may have on a registrant. The Induction Station, after it has examined the registrants, returns all such Forms to this Headquarters, where they are filed for referral when a registrant is sent to the Medical Advisory Board for further examination or when a registrant is to be resubmitted for induction.

The Validity Of The School Teacher Appraisal
And Social History (DSS Form 213 And DSS Form 212)

Considerable money has been allocated by the Federal Social Security Agency, and much time and effort on the part of the Selective Service personnel is devoted to assembling data on personality behavior patterns of registrants for the use of the Armed Forces to aid in the medical examinations and determinations at the Induction Station anent acceptability or rejection of selectees.

To determine their validity and also to ascertain how they were being used by the Armed Forces Induction examination station in the New York City area, the study herein outlined was undertaken.

The Public School System and the Parochial School System of New York City have enthusiastically cooperated in forwarding to this Headquarters the information required to be checked on Forms 213 for registrants recently graduated from the high schools.

There are now approximately 25,000 such Forms filed alphabetically here. Of these, 2,336 such Forms were selected for detailed study after they had been used by the psychiatrists at the Armed Forces Induction Station.

The results are shown on Chart No. I.

The difference in percentage between those accepted and those rejected after actual psychiatric examinations employing the Form 213 is shown in the third column. These differences would seem to the casual observer to be small. Projected against the 25,000 individual registrants represented in our alphabetical files of Forms 213, these percentage figures would represent large numbers as being represented in each category.

By withholding 284 Forms 213 from the Armed Forces Induction Station while the registrants represented by these Forms 213 were being examined at the Station, a sampling of adequate numbers was obtained to make a determination as to how the registrants would fare if no Forms 213 were available to the military examiners.

The determinations made at the Armed Forces Induction Station are shown in Chart II.

Summation: Contrasting Chart I and Chart II the following items are pertinent. Without the use of Form 213, the Armed Forces Induction Station accepted more men whose teachers reported reduced ability to study than they rejected. The Armed Forces Induction Station accepted more men who were truants in school than they rejected. They accepted more men disinclined to physical activity, or who engaged in none, than they rejected. They accepted more men ignored by their classmates than they rejected. They rejected more students designated "very cooperative" than they accepted. On the question of reliability, they rejected more marked "always cooperative" than they accepted.

The preinduction examination accepted more youths marked "moody," "suspicious," "deceptive," "having tantrums," more "strikingly immature," "day-dreamers," than they rejected.

Of those with physical defects known to their teachers, they accepted more having history of hay fever, history of heart trouble, than they rejected.

In all these determinations, there were from three to six individual teachers' appraisals available on each registrant made by teachers each independently of the other. Those rejected listed in Charts I and II, were all mentally disqualified.

Conclusion: It is very evident that the Forms 213 are used by the psychiatrists at the Armed Forces Induction Station. The subsequent review of the registrants' forms in the light of either acceptance or rejection, leave no doubt as to the value of processing these forms and having them at the Armed Forces Induction Station for study before the registrant appears for examination.

CHART I

From the Forms 213, the teachers' appraisal gives the following difference in percentage of those rejected against those accepted.

Number of DSS Forms 213		Accepted	Rejected	Difference
		1174	1162	
1	Is his school work getting poorer:			
	No	82.5%	79.4%	3.1%
	Yes	8.7	11.3	2.6
	If "Yes" do you attribute this to			
	Harder studies	20.6	17.6	3.0
	Other interests	53.9	48.1	5.8
	Reduced ability to study	20.6	29.0	8.4
2	Is he a truant?			
	No	85.9	82.4	3.5
	Yes	1.8	3.9	2.1
3	To what extent does he have difficulty in making up his mind?			
	None	52.6	44.7	7.9
	Moderately	31.3	33.2	1.9
	Has much difficulty	2.4	5.2	2.8
4	Participation in physical activities			
	Much	9.1	7.6	1.5
	Average	45.0	38.4	6.6
	None	1.8	6.8	5.0
5	Response from classmates			
	Accepted	84.9	80.3	4.6
	Ignored	5.5	7.4	1.9
	Disliked	.6	1.9	1.3
6	Attitude toward teachers			
	Very cooperative	40.3	38.3	2.0
	Usually cooperative	48.9	48.1	.8
	Uncooperative	5.0	8.4	3.4
7	Dependability			
	Always reliable	37.7	34.0	3.7
	Usually reliable	49.0	49.1	.1
	Unreliable	4.8	9.6	4.8

A breakdown of the uses the Station makes of the Forms and the social histories, compiled by our force of Medical Field Agents is appended, as Chart III.

To be again noted is our procedure of forwarding only social and psychiatric histories which are considered pertinent. Furthermore, by using the Master Psychiatric File which we compiled and which now contains about 66,000 names of admission to the Psychiatric Pavilions of both the Bellevue and the Kings County Hospitals, we are enabled to recommend classifications of IV-F to those registrants found to have such hospital records. Finally, by using the Sex Variant file, of Professor George Henry, of the Payne-Whitney Clinic of the New York Hospital, sexual perversions are substantiated and classification of IV-F at the Local Board level is in order, under our Regulations. Thus, a large percentage of social histories need

CHART NO. II

Forms 213 withheld from Armed Forces Induction Station, until preinduction examination had been completed.

Number of DSS Forms 213		Accepted 284	Rejected 284	Difference
1	Is his school work getting poorer:			
	No	76.1%	81.7%	5.6
	Yes	10.9	9.2	1.7
	If "Yes" do you attribute this to			
	Harder studies	9.7	15.4	5.7
	Other interests	67.7	53.8	13.9
	Reduced ability to study	22.6	23.1	.5
2	Is he a truant?			
	No	81.7	84.6	2.9
	Yes	3.2	1.1	2.1
3	To what extent does he have difficulty in making up his mind?			
	None	54.2	46.8	7.4
	Moderately	21.1	33.1	12.0
	Has much difficulty	2.8	3.9	1.1
4	Participation in physical activities?			
	Much	9.9	4.9	5.0
	Average	39.8	40.5	.7
	None	3.5	4.9	1.4
5	Response from classmates			
	Accepted	84.5	83.5	1.0
	Ignored	5.3	4.9	.4
	Disliked	.7	1.8	1.1
6	Attitude toward teachers			
	Very cooperative	39.1	47.2	8.1
	Usually cooperative	47.2	38.0	9.2
	Uncooperative	5.3	6.0	.7
7	Dependability			
	Always reliable	33.5	41.2	7.7
	Usually reliable	49.3	43.0	6.3
	Unreliable	8.8	8.1	.7

not be sent to the Armed Forces Induction Station, because these registrants are handled at the Local Board level.

Conclusions: The social histories are pertinent and useful to the examiners at the Armed Forces Induction Station.

During the last fifteen months of which detailed records have been kept, 260,621 registrants appeared at the Armed Forces Induction Station, for whom 12,816 social histories were forwarded, aggregating 4.92% of those being examined. Of these 5,953 were found to be pertinent and 6,863 were found non-pertinent at the Armed Forces Induction Station but considered pertinent by our Headquarters staff. Wherever the history seemed borderline or equivocal, the doubt was resolved by forwarding the history.

MEDICAL AND SOCIAL HISTORY STATISTICS

MONTH	SELECTEES SENT FROM CITY LOCAL BOARDS TO A.F.I.S.	SOCIAL HIST. SENT FROM L.B.'s to A.F.I.S.	PER- CEN- TAGE	TOTAL SOCIAL HIST. SENT FROM L.B.'s to A.F.I.S.	TOTAL PERT. SOCIAL HIST. SENT FROM CITY L.B.'s to A.F.I.S.	PER- CEN- TAGE	NON-PERT. SOCIAL HIST. SENT	PERT. INFORMA. LEADING TO REJECTION	PERT. INFORMA. LEADING TO ACCEPT.	CONCUR WITH NEURO- PSYCH. DIAGNOSIS AT A.F.I.S.	PERT. BUT NON- CON- CUR- ING	PERT. TO OTHER DEPTS. (NOT NEURO- PSYCH).
<u>1944</u>												
FEB.	47,851	183	.38	183	104	56.83	79	21	12	26	16	15
MAR.	51,842	3,595	6.9	3,595	964	26.82	2,631	40	2	364	57	287
APRIL	36,332	2,028	5.58	2,028	607	29.93	1,421	26	0	133	11	227
MAY	26,466	925	3.49	925	457	49.40	468	45	3	118	6	219
JUNE	11,135	486	4.27	486	304	62.55	182	59	8	124	10	158
JULY	6,794	495	7.29	495	332	67.07	163	122	10	200	7	145
AUG.	4,067	280	6.9	280	197	70.35	83	85	25	120	17	75
SEPT.	4,473	330	7.03	330	267	80.09	63	144	55	213	31	116
OCT.	4,311	389	9.04	389	271	69.66	118	158	77	224	31	129
NOV.	3,810	484	12.70	484	337	69.92	147	192	118	118	248	196
DEC.	3,409	361	10.59	361	232	64.26	129	141	82	160	65	139
SUB- TOTALS	200,490	9,516	4.7	9,550	4,072	42.63	5,484	1,033	392	1,930	312	1,706
<u>1945</u>												
JAN.	10,999	815	7.40	815	531	65.15	284	321	207	352	165	249
FEB.	11,780	737	6.25	737	376	51.02	361	209	167	263	113	192
MAR.	17,096	878	5.13	878	478	54.44	400	246	232	359	119	309
APRIL	20,254	830	4.18	830	496	59.75	334	265	331	359	137	328
SUB- TOTALS	60,131	3,260	5.4	7,038	2,949	41.88	1,379	1,041	937	1,333	534	1,078
TOTALS	260,621	12,776	4.9	16,588	7,021	42.3	6,863	2,074	1,329	3,263	846	2,704

2,074 gave pertinent information leading to the registrant's rejection, while 1,329 gave histories which substantiate acceptance. In 3,133 cases, the social history concurred with the neuropsychiatric diagnosis at the Armed Forces Induction Station. The Armed Forces Induction Station considered 1,033 social histories pertinent but did not concur with the social-psychiatric workers' (Medical Field Agents) findings.

Finally, in 2,784 instances, the social history while not pertinent to the psychiatric examiners was nevertheless found of pertinence to other medical specialty departments at the examination post.

Salvage Of Needles For Serological Tests

Due to the large quotas and the fact that it was becoming harder and harder to secure supplies at this time, the New York City Department of Health was forced to request that the doctors return the serological needles after they were used, so that they might be salvaged for further use. This request was met with the utmost cooperation.

Revision of DSS Form 220

On January 30, 1943, the List of Disqualifying Defects, DSS Form 220, was revised so that it listed additional defects which would allow the Examining Physicians to disqualify a registrant at the Local Board level. These additional defects consisted mostly of chronicities which were obviously disqualifying. Among these were Addison's Disease, Chronic Alcoholism, Pernicious Anemia, Diabetes Mellitus, Hypoglycemia, Insanity without commitment when the registrant was actually in an institution for the treatment of such diseases, Mutism, Parkinsonian, repeated positive serologies, and active peptic ulcer, confirmed by X-ray. This was done for the purpose of facilitating the work at the Induction Station and to save such obviously disqualified registrants the trouble of going to the Induction Station for an examination.

Review Of Registrants Classified In IV-F

In October of 1942, this Headquarters initiated an inspection of the cases which had been disqualified at the Local Board level to see whether any could be salvaged, and also for the purpose of checking on any possible errors. This Headquarters had always reviewed the Report of Physical Examinations of all registrants who were disqualified for service, both at the Induction Station and at the Local Board level. However, there always were some Local Boards who did not send in these Forms immediately for review.

A select group of twenty-five doctors was chosen to organize this work and as usual they were both enthusiastic and cooperative in spite of their already heavy programs.

Another specific reason for this review was the fact that in May, 1942 the standards had been liberalized so that some conditions which had previously been considered totally disqualifying were then made acceptable for limited service, or for general service. Among these were the following:

<u>Defect</u>	<u>Now Acceptable For</u>
(Previously IV-F) Perforation of the membrana tympani provided there is a trustworthy history of no symptom of otitis media or disease of mastoid during preceding two years	Limited service
(Previously Limited Service) Hernia, small umbilical (patent umbilical ring)	General service
(Previously Limited Service) History of cholecystectomy provided there are no residual disqualifying sequelae	General service
(Previously IV-F) Undescended testicle which lies within the inguinal canal	Limited service
(Previously IV-F) Large benign tumors of the abdominal wall	Limited service
(Previously IV-F) Internal and external hemorrhoids, moderate	Limited service

<u>Defect</u>	<u>Now Acceptable For</u>
(Previously Limited Service)	
Benign tumors of the breast or of the chest wall, provided the mass does not interfere with the wearing of a uniform or military equipment	General service
(Previously IV-F)	
Pellagra, beriberi, scurvy, and other nutritional deficiencies, if mild and remediable by diet and appropriate treatment	Limited service
(Previously IV-F)	
Chronic blepharitis	Limited service
(Previously IV-F)	
Pterygium encroaching on cornea	Limited service
(Previously IV-F)	
Deviation of nasal septum which markedly interferes with nasal breathing	Limited service
(Previously IV-F)	
Nasal polypi, if mild or moderate and not accompanied by evidence of chronic sinus disease	Limited service
(Previously IV-F)	
Chronic diseases of the skin of the type which disqualify for general military service, provided the individual has successfully followed a useful vocation in civil life	Limited service
(Previously IV-F)	
Individuals who are well nourished, of good musculature, are free from gross dental infections, and have a minimum requirement of an edentulous upper jaw and/or an edentulous lower jaw, corrected or correctable by a full denture or dentures	General service

The final results of this inspection were available in June, 1943 and showed the following: of 134,558 cases inspected, 5,507 were found doubtful and were ordered for re-examination at the Induction Station (approximately 4%). Of the cases submitted to the Induction Station, 171 were finally accepted, or .001% of the total cases reviewed.

As small as this percentage of cases finally accepted is, it is still smaller when one takes into consideration the fact that most of the cases accepted were the result of the change in standards as noted above, and not the result of errors of diagnosis. These same standards were later changed back to what they had been originally, and most of the registrants accepted with perforated eardrums and undescended testicles were later discharged from the Armed Forces. The review did show that the percentage of error on the examinations was almost infinitesimal and for this reason alone it was worth the effort.

Cardiovascular Review

A pilot test upon cardiovascular rejections by Local Board physicians and Medical Advisory Board specialists was made upon one thousand such in the New York City area in January, 1943. A report upon such tests, held also in Boston, Chicago, Philadelphia, and San Francisco was made by a national committee of heart specialists. This report and the findings at the special reexamining station established at the Presbyterian Hospital, Columbia University Medical Center, were submitted to me and upon the request of Colonel Rowntree, Chief Medical Officer of Selective Service, I rendered a report and critique at the meeting of Medical Officers in Washington, D. C., on June 6, 1944.

The report is as follows: --

The reestimation of registrants rejected both by the Medical Advisory Board physicians and by the Induction Station examiners undoubtedly was prompted by prevalent opinion among specialists in cardiovascular disease that the diagnosis of heart conditions and lesions by Local Board physicians, and Medical Advisory Board specialists, made under the pressure and apparent hurry of the routine examinations were disqualifying large numbers of men for heart

murmurs, hypertension, enlargement of the heart, and neurocirculatory asthenia, which upon a review by a specially selected group of cardiovascular specialists might prove to lack diagnostic substantiation in many instances. In other words, it was thought that many were incorrectly disqualified for military service.

It was hoped also that as a result of such review and reexamination a considerable salvage of manpower for the Armed Forces might be obtained

In planning the pilot test Boston, Chicago, New York, Philadelphia, and San Francisco were selected as the cities where the reexamination should be made. These cities were selected in spite of the fact that in all these centers of large population aggregations, it was to be expected that competent and qualified physicians were available to the public, and also to Selective Service, to man the Medical Advisory Boards.

In the New York City area, summarizing our experience, I find that of the 1,000 resubmitted to the pilot test 494 had been originally disqualified at the Local Board level. Of these rejected at the Local Board level, the rejection was substantiated in 378, leaving only 116 whom the special group of cardiovascular specialists recommended to be resubmitted to the Induction Station. There were 506 originally disqualified by the Army Induction Station examining specialists. Of these, only 77 were recommended by the special Medical Advisory Board of cardiovascular specialists to be resubmitted to the Army examining team. Thus, of the 1,000 selected from the New York City area to be reexamined only 193 were recommended for resubmission. One additional registrant was resubmitted to the Induction Station before the special Medical Advisory Board report on him, and he was accepted for military duty. Of the 193, when reexamined at the Army Induction Station and the examiners having before them the detailed report of the special Medical Advisory Board's findings, 140 were accepted for military duty, and 37 were again rejected. There was a further loss of 17 who, for various pertinent reasons, were given deferred classifications by their respective Local Boards. Summarized, this means that of the 1,000 registrants with prior rejections for cardiovascular disqualifications, 14% were accepted after special review for Army, Navy, and Marine Corps service. 3.7% were again rejected, and 1.7% were deferred because of socio-economic reasons. The prior diagnosis warranting a IV-F classification was substantiated in about 80.6% of the 1,000 registrants; namely, 807 of them.

One other item needs notation. Of the 14% accepted for military service (140 registrants), I have received information up to date that 24 of them have been discharged for medical reasons, mostly because of heart conditions (exact diagnosis not available to me), leaving at this time only 11.6% or 116 men of this group, still in the service.

As a means of salvage of manpower for the Armed Forces, this review of cardiac rejections in the New York City area has not yielded impressive results.

To be noted is the factor already alluded to above, that the test was made in large city centers of population, where there are outstanding medical facilities available. Naturally, some of the very men who are serving on Medical Advisory Boards served on this special Medical Advisory Board; likewise, the heart specialists who, as civilians, serve at the Induction Station examining teams as heart specialists are, in some instances, physicians who previous to their appointment had served as examiners on Medical Advisory Boards.

I hazard the assumption that had the places selected for the test been in areas or sections of the country less adequately supplied with cardiovascular specialists that a larger salvage of men for the Armed Forces might have been obtained. Please note that this is only an assumption on my part, for I have no substantiating data to permit me to accept this assumption as an established fact.

There is a factor at issue that needs consideration. In medicine one cannot set up a fixed level of diagnostic acumen, particularly where there is a large number of different examiners at work at the numerous stages and places of examination in the process of recruiting our manpower for the Armed Forces. Diagnostic acumen differs even among those rated by their fellows as experts. Hence, the same individual presenting exactly the same symptoms and findings will receive a different diagnostic opinion from one or the other expert who examines him. One is permitted, however, to establish certain yardsticks as guides, when acceptance or rejection for military service is at stake. Therefore, it is but natural to expect that there will be varying results within a given range between the different examining teams in differing localities and at different stages of examination for induction into our Armed Forces.

In reading the report published by Drs. Levy, Stroud, and White, of the Subcommittee on Cardiovascular Disease of the National Research Council, I can find very little difference, except in minor percentage figures, between Boston, New York, Chicago, and San Francisco. One may speculate how interesting it might be to contrast findings of the large urban centers with those of men from rural areas, where the medical profession has less access to electrocardiograms, fluoroscopy, and X-ray technical assistance in their daily practices and there is a different level, perhaps, of detailed diagnostic acumen prevalent in the professions in these large cities than might be found to exist in rural centers.

We can agree with the findings of the report made by the Cardiovascular Subcommittee of the National Research Council in regard to the following important points. We are repeating them here briefly for the sake of emphasis, and in addition have added here and there some of our own experiences.

1. The Differentiation of a Functional from an Organic Heart Murmur. A systolic murmur at the cardiac apex is commonly found in both health and disease. A murmur that was slight, but not very marked in the apex, which is either not transmitted at all toward the axilla or only partly heard on the line toward it, particularly if it is late in its timing, and when it is found in the absence of evidence of cardiac enlargement or a diastolic murmur, or furthermore, in the absence of a history of rheumatic fever, is to be considered as within normal limits. This is the more so if the systolic murmur varies greatly, if the murmur disappears entirely with change in bodily posture or with a change in respiratory rate. This functional murmur gave our examiners in Selective Service the most difficulty and, as a matter of fact, there still is not a settled opinion on the significance of even the intensity of a heart murmur. The Committee believes that a loud apical systolic murmur is generally to be considered a cause for rejecting the registrant.

Aortic murmur signifying stenosis is always to be considered as cause for rejection. Slight sternal murmurs at the left lower sternal region of uncertain origin were encountered by the test examiners a few times and they also found pulmonary systolic murmurs when the subject lay on his back and which were heard distinctly upon expiration, particularly if loud and persistent. These were held as cause for rejection.

The Local Board examiners rejected many cases in which there were extra cardiac scratch sounds or the so-called systole, which is sometimes termed the "systolic click." These men should be acceptable.

2. Blood Pressure Levels. This presented a problem both to the Local Board examining physicians and to the test examiners. MR 1-9 lists 150 mm for systolic and 90 for diastolic as within normal limits for the majority of registrants at rest, but taking into account the nervousness and excitement incident to the examination itself, 160 to even 170 could be considered normal, provided the diastolic was not too high. If the diastolic was 95 it again brought into question the acceptance or rejection of the registrant. Here it is to be noted that many registrants indulged in an excess of liquor drinking before going to the examining post and this factor should be remembered when judging blood pressure levels.

Mild hypertension attended by nervous tachycardia, where the elevation of the blood pressure was accompanied by a low heart beat rate or even an average pulse rate is considered a serious condition and cause for rejection.

3. Pulse Rate. In the absence of authenticated evidence of heart disease, thyrotoxicoses, or physical ailment responsible for tachycardia or neurocirculatory asthenia, a pulse rate of 110 with a range up to 120 would seem to be acceptable. It must be noted in passing that the pulse rate is the poorest criteria for estimating cardiovascular fitness. However, an authenticated history of tachycardia should be respected.

4. The determination of the normal size and shape of the heart presents another difficult problem to solve by any method of examination including actual measurements on X-ray findings. The New York special Medical Advisory Board held the measurements made by the Hodges-Eyster formula as inadequate to determine the size of the heart. The standard agreed upon was 1 cm for the upper normal limit greater than the transverse diameter calculated by the Hodges-Eyster formula. This group noted that men of unusual stature, rather short with wide chests and shoulders, which resulted in perfectly normal cardiothoracic ratios; i.e., the transverse diameter of the heart not being over 50% of the internal diameter of the thorax.

Such they consider as within normal ranges. Height and weight alone do not indicate variations in normal body build, and no criteria is as yet at hand to make individual decisions as to the actual size of the given man's normal heart.

5. There are Difficulties in Interpreting Electrocardiography. This is also true when studying X-ray shadows in regard to heart size. The full range of the normal has not yet been satisfactorily established to the satisfaction of cardiovascular experts.

Habitually X-ray technicians ask that patients take a long breath and hold same, with arms extended against the frame holding the film. In estimating the size of the heart, in questionable cases, it is better technique to have the registrant take a casual inspiration, and take the film during the casual inspiratory phase of a respiratory act. Thus a picture more accurately approximating the actual relationship of heart size to chest size is obtained than when the chest is expanded by a forced inhalatory effort.

6. Neurocirculatory Asthenia Presents Two Problems. The first one is concerned with the recognition of the condition itself, and the second with the acceptability of men with slight grades of this condition. The examiner must decide to reject men with various grades of this condition, and the examiners in the New York area decided to reject men with even the mildest form of this condition. The recognition of neurocirculatory asthenia is extremely difficult in mild cases. The diagnosis rests at present on the history of symptoms. Sometimes it rests upon actual and prolonged testing rather than on physical signs; namely, pulse and blood pressure ratings. Let me add that if rectal temperature is elevated then it speaks for hyperthyroidism rather than neurocirculatory asthenia.

The syndrome includes, as you are well aware, a combination of dyspnea, usually accompanied with sighing, palpitation, heartache, and exhaustion on relatively little effort or excitement. In civil life it is generally attended by some definite psychoneurosis, particularly of the anxiety type.

In the New York City area we have had very few rejections for neurocirculatory asthenia. This diagnosis was a cause for rejection in only 77 instances among the many thousands of rejections of our registrants. I hold this due to the efficient screening out of psychoneurotic cases. There are probably many not diagnosed as neurocirculatory asthenia who had its symptoms. They were disqualified for service with a diagnosis of psychoneurosis, which I believe is correct.

At the Signal Corps Station at Fort Monmouth, New Jersey, the Squier Laboratory is carrying on a test project specifically studying neurocirculatory asthenia. In a mutually satisfactory arrangement made with the Chief Medical Officer at the Station, a substation of his laboratory was established in the New York City area to study these 77 registrants, who were invited to cooperate in this study. Thus far, however, only five have responded to the invitation and since we cannot direct them to go for the study, I do not believe much has been determined as yet.

7. Rheumatic Fever. The exclusion of registrants simply on the ground that they present a history as having had an attack of rheumatic fever in childhood, or even more than one attack, in the absence of any physical evidence of heart damage, has seemed to me an unwarranted loss of manpower to the Armed Forces. On the other hand, the undesirability of accepting those with an authenticated history of rheumatic fever within five years, even though the heart seems normal, I believe warranted the rejections which were made.

8. The Exercise Tests. I do not hold to be more than a test of general fitness of the subject rather than an indication of the condition of his heart. This is in accord with the opinion of the special Medical Advisory Board in the New York City area.

In conclusion, it becomes obvious from this study, as well as from other matters having to do with selection of manpower for the Armed Forces, that there is a need for a continuing study of medical problems with reference to selection of individuals for military service. This should be the assigned duty of some section of the Surgeon Generals' Departments of both the Army and Navy. This section should function not only in times of war emergency, but in times of peace also.

The translation of the civilian physician with his acquired contact with sick civilian does not necessarily qualify him to be able to make conclusive determinations of the registrant's acceptability or unsuitability for the Armed Forces. There is need for the education

of a group of the medical personnel of both Army and Navy to fix the criteria of acceptance and rejection based on their knowledge of the demands which military life require from the personnel of the Armed Forces. Anything less can be construed as improvisations by medical men in the hope of meeting current problems of war emergency. The problem of cardiovascular rejections and acceptances would fall naturally within the scope of such a study. The more leisurely procedures possible during peace time would permit a much better study with better periods of observations of the results of changes recommended. To do this during war time is extremely difficult, and hardly satisfactory.

We cannot escape the conclusion that we are wasting manpower to some extent by rejecting usable recruits and, to a larger extent, are drawing from industry many who are unfit for Army life. The latter men break down in training camps, and thereupon become unfit to return to industry. This breakdown and subsequent unfitness for work in industry after a disability discharge dates back to the mental attitude of these cardiacs. This test has shown that most of the men involved were well aware of their cardiac disability, and had so regulated their private lives that they were gainfully employed and functioned as useful members of their communities. On the other hand, others were told, year in and year out, not to take any exercise, to take things easy, etc., etc. Thus there was created in those having a functional murmur, incorrectly estimated by their private physicians as an organic one, such a degree of phobia for anything approaching muscular exercise that it is indeed surprising so few broke down in service of the 140 accepted; namely, only 24 separated from the service to date, of which I have knowledge.

One other factor needs notation. I differentiate between the standard of acceptability for military service and the usability of the recruit thus accepted.

After the recruit reports to the Reception Center, he is assigned to specified units in the Armed Forces - Infantry, Artillery, Transport, motorized units, Quartermaster Corps, etc., etc.

To some extent there is fault in the assignments made.

To some extent this assignment is predicated upon the aptitude tests and prior experience in civilian life. I have never seen medical opinion correlated with the determination of the assignment of recruits to active duty.⁴ I believe this is a factor which needs consideration when the whole process and procedure of procuring manpower for the Armed Forces comes under review and revision in the post-war period when planning is under way for the procurement of recruits for our peace time Armed Forces. From the study of procurement of personnel for the Army and Navy, the foundation should be made for the inevitable expansion which war necessitates. Medical opinion should be integrated with the opinions of the assignment officers, particularly in those cases having functional heart murmurs.

Let it be said, however, that no individual nor any one agency of Government is solely responsible for the situation as it exists today. On this problem alone, and on the methods of procedure to correct the situation, a veritable thesis could be written. This is neither the time nor place to present the ideas inherent in a plan which would tend to obviate the situation as it is and as I see it.

Suffice unto today is the problem before us. I have sketched the outcome of the test as it affected the area under my medical jurisdiction. To do more at this time would lead me too far afield.

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In May of 1943, as a result of pressure by the Local Boards and registrants, it was determined to permit preinduction examinations for certain registrants. This was for the purpose of allowing registrants who had doubtful physical conditions an examination so that they would know whether or not to wind up their personal affairs and business, thus eliminating financial loss and personal sacrifice.

In June, 1943 the Local Boards were ordered to remove all registrants qualified for limited service from a IV-F category and to resubmit them to the Induction Station for examination. This was at a time when the induction quotas were still at a very high peak and

there were a great many positions which might be filled by men with limited service defects.

In October, 1943 it became necessary to call upon the Medical Advisory Boards to help check on cases rejected by the Induction Station, which appeared doubtful to the Local Board because of the registrant's background, lack of medical verification, or because of complaints received. Naturally, with the large numbers of registrants being examined at the Induction Station it was impossible for the Induction Station examiners to delve into the registrant's background, etc. As usual, the Medical Advisory Board was immediately cooperative - although no laboratory procedures were permitted.

Also due to the great number of limited service positions available at this time, the physical standards were liberalized so that an inguinal hernia which had not descended into the scrotum, which formerly was rejected for either general or limited service, was made acceptable for limited service. Therefore, on November 30, 1943 an order was issued to all the Local Boards that they review all their hernia cases and send them to the Induction Station for further determination.

In January, 1944 this Headquarters was advised that beginning in February, 1944 pre-induction examinations at the Induction Station would be resumed and therefore, there would be no necessity for any further screening examinations by the Examining Physicians of the Local Boards. From the standpoint of the registrant this was very satisfactory for it gave him a more accurate decision as to whether or not he would be accepted at the Induction Station. However, it was modified so that if a registrant felt that he had an obviously disqualifying defect he might request a Local Board examination and still be disqualified at the Local Board level if he had one of the defects listed in DSS Form 220. The preinductions were reactivated at this time probably because the induction quotas had decreased at this point and the Induction Station was able to handle both preinduction and induction examinations.

Accordingly, a meeting was called of all the Chiefs of the Examining Teams to advise them regarding the discontinuance of the screening examinations.

At this same time fathers and men in the older age brackets were being inducted, which meant that a great many dependency cases came in for determinations. In many cases, the prime factor involved was the health of one or the other of the dependents. This Headquarters had advised the Local Boards that the burden of the proof regarding the illness of dependents rested with the registrant, but that if a determination could not be made by the Local Board on the basis of the certificates submitted this Headquarters would examine the dependent and render an opinion. The registrants were asked to submit certificates regarding the alleged physical conditions of their dependents. However, in a great many cases the information secured was insufficient or too vague, and in those cases the Local Boards were advised to submit the certificates to this Headquarters for an opinion. When it was deemed necessary, appointments were made for the dependents to come to the Medical Division for examination by a group of doctors who had volunteered to do this work at this Headquarters. It was found on examining these dependents that 50% of the certificates submitted were exaggerated.

The cases referred to this Headquarters had become so numerous that it was necessary to have four doctors on duty at this Headquarters. In spite of this, there were still more examinations than could be handled comfortably. Therefore, when the screening examinations were eliminated the Local Board Examining Physicians were requested to do the examinations of these dependents for the different Local Boards. This they undertook to do.

In February of 1944, the Medical Survey Program was in full operation. By this time, psychiatric social workers had been assigned to every Local Board, with few exceptions. To cover the Local Boards to which it was not possible to assign any psychiatric social workers, because of location, etc., a Headquarters unit of psychiatric social workers was established. This unit consists of about twelve psychiatric social workers who come in every Tuesday night and interview the registrants from Local Boards not covered by psychiatric social workers specifically assigned to them.

In the beginning of the program, since the quotas were quite high, it was impossible for the psychiatric social workers to do more than interview those cases which were especially referred to them by the Local Board personnel. However, as the procedure became more routinized and the quotas gradually decreased, the psychiatric social workers found time to interview practically every registrant before he was sent down to the Induction Station for a preinduction examination.

Headquarters Master Psychiatric File

The Medical Identification Cards which were sent to the New York State Department of Mental Hygiene for clearance were discontinued in December of 1943 because the New York State Department of Mental Hygiene was so flooded by the great number of cards arriving there every day that they were unable to keep up with the necessary checking.

Since it was very necessary to have some check on the registrants as to previous admissions to hospitals for some mental condition, this Headquarters established what is now known as the Bellevue-Kings County file. This file consists of an alphabetically filed card for every registrant within the draft age who at any time was committed or admitted either to Bellevue or to Kings County Psychiatric Divisions, giving the dates, diagnosis, etc. In order to establish this file it was necessary for volunteers to be recruited from this Headquarters and from the social service agencies to go to Bellevue Hospital and Kings County Hospital every night to copy the necessary information from the records. This work went on for about five months but it was the means of establishing a very vital part of the Medical Survey Program. The file is being kept up to date.

Naturally, as this program progressed the staff assigned for this work increased until at present there are eight clerks to do this work. Recently, the Social Service Exchange entered the program and now one of the representatives of this agency has been assigned to this Headquarters, and in addition, the names of all the registrants to report for preinduction are now cleared through the Social Service Exchange files, thus giving us further clues to the registrants' past history.

Adjustments Of Complaints And Errors

For some time registrants had been coming in to this Headquarters to complain regarding the examinations received by them at the Induction Station. Those who were accepted felt sure they had some defect which was disqualifying and for which they should have been rejected; and those who were rejected simply must get into the Army and were sure they had absolutely nothing wrong with them.

These cases were given all the consideration possible, and if there did seem to be some basis for the complaint the case was taken up by this Division with the Chief Medical Examiner at the Induction Station. As a result of these conferences, which were held on an average of once a week, determinations would be made and the registrants would be advised either that they were to be resubmitted to the Induction Station for another examination, or that they had been correctly accepted or rejected, as the case may happen to be. Thus, many registrants who were formerly disgruntled with Selective Service became satisfied that everything possible was being done in their behalf.

In July of 1944 the Induction Station ceased taking any men who were qualified for limited service, since there were no more available limited service positions to be filled. In November, orders came through from National Headquarters that all men who had been qualified for limited service only were to be reclassified in IV-F.

The latest development at this time is that all IV-Fs who held essential positions and have left them without permission of the Local Board, after December 12, 1944, may be processed for induction in spite of their defects, and may be inducted.

In the foregoing there has been presented a running chronological account mostly concerned with the principal duty assigned to the Medical Division, namely matters concerned with the medical examinations of men, to select those physically and mentally fit for service in the Armed Forces, measured by the standards and criteria set for military service.

The details in brief outline of ancillary functions carried out by the Medical Division also are noteworthy, and there follows the records made in these functions.

Review Of Physical Examination Forms And
Approximate Estimates Of Numbers Examined,
Numbers Accepted, And Numbers Rejected

There have been inducted from New York City, to May 7, 1945, 620,804⁵ registrants into the military services. Of these, 607,378 were inducted by the Local Armed Forces Induction Station, while an additional 13,426 of New York's registrants were inducted at Armed Forces Induction Stations outside the New York City area.

Since the commencement of Selective Service, this Headquarters has processed and forwarded for examination 1,104,806 registrants.

The numbers rejected because they failed to qualify mentally or physically under the provisions of MR 1-9⁶, both at preinduction and at induction examinations amounted to 353,026.⁷ In regard to these figures, it should be noted that when the figure for those rejected is deducted from the total number examined the figure 484,002 will result. This figure is 130,976 more than the figure given for the number rejected. The difference is due to the fact that these 130,976 men were actually found acceptable for military service by mental and physical examinations, but were not inducted because of reclassification by their Local Boards.

Some also were qualified at the Armed Forces Induction Station at their preinduction examinations but when they subsequently came up for induction examinations they were disqualified. There are no figures available on the numbers to whom these happenings occurred. In the four years under report, the overall figures given herein are all that are available.

The figures of those rejected at the Local Board level because they presented themselves with obviously disqualifying defects which were listed in DSS Form 220⁸ are not available.

The Medical Division scrutinized every Form 200 and Form 221 of all rejected registrants. There were 32,912 that denoted errors necessitating corrections. In the subjoined table the details of this activity of the Medical Division are shown from April 28, 1941 to May 8, 1945.

TOTAL NUMBER FOR CORRECTION.....	32,912.....	100%
Inducted.....	6,810.....	20.7%
Rejected.....	14,285.....	43.4%
By Local Board Doctor.....	8,185.....	24.9%
By Induction Station.....	6,100.....	18.5%
Accepted, not yet inducted.....	73.....	.2%
Classified I-A-L.....	81.....	.2%
Other classifications.....	3,321.....	10.1%
Deceased.....	28.....	.1%
Pending.....	4,403.....	13.4%
Technical errors corrected.....	1,336.....	4.1%
Conditions verified.....	2,575.....	7.8%

⁵ The actual figures of those in the Armed Forces, as of January 1, 1945, is approximately 800,000. The difference between this figure and that in the text lies in the fact that the figures in the text comprise only those sent for induction by Selective Service Local Boards and do not include those who upon their own initiative volunteered and entered the Armed Forces.

⁶ War Department Standards of Physical Examination During Mobilization.

⁷ This figure is only an approximation because there were necessarily duplications of examinations, because some registrants have been sent to the Armed Forces Induction Station examinations more than once.

⁸ List of Manifestly Disqualifying Physical Defects, Bureau of Selective Service, December 31, 1942. Revised January 16, 1943.

Investigation Of Physicians' Certifications Of
Registrants' Dependents' Disabilities

There have been claims asserting that hardship would result were certain registrants to be inducted into the Armed Forces because the registrant was necessary at home due to the inability of the registrant's dependent to engage in gainful occupation.

In certain instances, the certifying physician's statement of the condition was clear and definite. In many instances the Local Board's Examining Physician could and did make the determination to the satisfaction of the Local Board, who thereupon made the necessary adjustments of classifications. In a certain number of instances, either the Local Board physician could not or did not make determinations, and in other instances the Local Boards were not satisfied with the determinations made. It was necessary, therefore, to establish an examining team of doctors at Headquarters. This team was set up comprising four doctors of large general medical experience who gave their time and skill voluntarily. They were:

Dr. William A. Rodgers
Dr. E. Z. Epstein
Dr. A. L. Goodman

Dr. L. Rau

Dr. Edward L. Gainsburgh
Dr. George B. Dorff
Dr. D. K. Zongos

The entire staff of examining physicians, all of whom had regular appointments as Selective Service Examining Physicians, did not function during the entire period of this report. Dr. A. L. Goodman dropped out due to a severe illness which still confines him to his home. Drs. Rau, Epstein, Zongos, and Dorff ceased functioning after the high peak load of inductions dropped to a level where so many physicians were not needed, and at the present Dr. Rodgers carries the main burden of the work, putting in a full work week, while Dr. Gainsburgh serves two half days weekly.

There were 6,346 medical certificates reviewed and evaluated. Of these, 2,787 were substantiated. 3,559 were upon study found not to be substantiated and the claims made, based upon the alleged disabilities described in these medical certificates, were disallowed.

In a number of cases, where the doctors' certificates were so indefinite and a doubt existed, or because before a determination could be made, an actual physical examination was necessary, there were 2,434 such physical examinations of registrants' dependents made by the Headquarters staff of volunteer doctors. Of these 45%, or 1,095, were found able to be employed, while 55% or 1,339 were found to be physically disabled and hence unemployable.

Interim Physical Examination Of Registrants

After a screening examination by Local Board physicians and a complete physical and mental examination at the Armed Forces preinduction station, 1,188 registrants came in and presented medical certificates, X-ray films, or hospital records with the end in view to show that an error was made in the determination of their physical or mental condition.

The Headquarters examining staff of volunteer physicians examined the medical evidence and where necessary made actual examinations of the men. 163 of such examinations resulted in recommendations being made that these be resubmitted for reconsideration and further evaluations of their acceptability for general military service, or where they had previously been accepted, for reconsideration because they had conditions or diseases which under MR 1-9 should have resulted in their rejection. Of those reconsidered, 67 cases resulted in a change being made in their status.

Examination Of Men Discharged With C.D.D.

Lately men honorably discharged with certificates of disability who were anxiously desirous of returning to the Armed Forces necessitated making 24 examinations upon such men. The results of these examinations became the basis for recommendations to Local Boards either to reprocess such as were found fit for service under MR 1-9, or to advise Local Boards that despite the voluntary effort of such discharged soldiers to re-enter the Armed Forces, the condition they presented when examined here was such that it precluded their acceptance under MR 1-9. Thus we were able to save time and wear hours at the Local Boards and at the Armed Forces examining posts.

The New York City Headquarters is deeply indebted for the fine service these volunteer physicians, headed by Dr. William A. Rodgers, have been donating to the Medical Division of the New York City Headquarters of Selective Service in particular and to the war effort in general.

Procurement Of Professionals For Military Duty

The procurement for military service of doctors, dentists, and doctors of veterinary medicine came partly to be the concern of Selective Service. Primarily based on memorandum from National Headquarters, that when considering the status in Selective Service of these professionals, inquiry should first be made of the New York State Procurement and Assignment Service as to whether or not the individual registrant under consideration was essential to his community in his civilian capacity. In the event that he was reported available for military service, the wonted regulations and procedures of our system anent him could be brought into action toward inducting him.

On the other hand, Bulletins from this Headquarters pointed out to Local Boards that the usual standards and criteria for estimating hardship and financial stress could hardly be applied to these professional men, because if they accepted the commissions which were available to them their pay and other financial allowances sufficed to cover their needs. Obviously, there must nevertheless be sacrifices involved, because some of even the younger group were definitely earning more money than what the Army or Navy pay provided.

The joint purpose of both the Procurement and Assignment Service and ourselves was to furnish the Armed Forces the quota of professionals set for New York City, yet at the same time exercise care that the community would not be stripped of needed medical and dental personnel to man our hospitals and Board of Health facilities, as well as the teaching staffs of our medical and dental schools.

Throughout the four years herein reported, an excellent spirit of cooperative endeavor was enjoyed between Dr. Henry Cave, the Chairman of the Second Service Command Area, and Dr. Joe R. Clemmons, New York State Chairman, and Commander William McGill Burns, USNR, the Executive Officer of the Regional War Manpower Commission, Procurement and Assignment Service and ourselves. Likewise with the Medical Officer Recruiting Board at 39 Whitehall Street, and the Office of Naval Officer Procurement at 33 Pine Street, New York City. The officers at these posts gave wholehearted support and cooperation.

Of the 7,013 cases of professionals who were registrants in Local Boards in our jurisdiction, 137 came to see me for personal interviews. These and the remainder were eventually handled through correspondence which went two ways namely, to the Local Boards and to our Washington Headquarters.

The detailed breakdown, as of May 8, 1945, is as follows:

Commissioned in Armed Forces and/or U. S. Public Health Service	1179
Disqualified physically for commission in Army or Navy.	4255
Unlicensed, hence ineligible for commission	15
Aliens, ineligible for commission	80
Inducted by Local Boards with our approval.	17
Over 38 years of age, not subject to Selective Service induction.	558
Declared Essential by Procurement and Assignment.	365
Out of town or country - not in our jurisdiction.	262
Declared Available - Local Board classified III-D	16
Declared Available - Classified IV-F - Rejected by Army Induction Station	59
Discharged from Army or Navy.	39
Disqualified for other than physical reasons.	73
Classified I-A-L.	5
Classified IV-E	1
Classified IV-C	1
Classified II-B	1
Deceased.	3
Classified I-A - Father -No action, to be inducted when others in this group are inducted.	2
Pending	82
TOTAL	7013

Classification Of Registered Pharmacists

The large numbers of drug stores in the City of New York is obvious to any one walking any of our streets. Some of these are glorified general stores, and some are really small restaurants. The number of drug stores in existence could not, therefore, be considered an index of the essential numbers of registered pharmacists who warranted being recommended for deferment because of essential pharmaceutical needs of the civilian population. The New York State Board of Pharmacy in a statment submitted to us, maintained that to maintain adequate public health services, the ratio of pharmacies to the civilian population should be 1 to 1,500. The ratio of pharmacists in New York State, in March, 1943, was 1 to 2,064 population, while in New York City, the area under our jurisdiction, the ratio was 1 to 1,150. From these figures it was evident that we in New York City had more drug stores than were needed, and yet had probably fewer pharmacists than we "comfortably" needed, particularly should the city be visited by an epidemic disease.

Under Occupational Bulletin #44, (Health and Welfare Services), authority was provided for serious consideration to Local Boards for occupational classifications to pharmacists considered doing essential work.

There was established at this Headquarters a Pharmacy Advisory Committee comprising the following:

Mr. Robert R. Gerstner	Dean Charles W. Ballard
Mr. Marty H. Sasnor	Dean Hugo H. Schaefer
Mr. William deNeergaard	

The composition of this Committee was such that on it were a representative of the New York State Board of Pharmacy, Mr. Robert R. Gerstner, two Deans of Colleges of Pharmacy, namely Dean Charles W. Ballard of the Columbia University College of Pharmacy, and Dean Hugo H. Schaefer, of the Brooklyn College of Pharmacy, Long Island University, and the others were representatives of practicing pharmacists and owners of non-chain, ethical drug stores.

This Committee met weekly and made recommendations anent pharmacists under consideration for classification by their Local Boards.

The following is the summary of the cases and the type of recommendations submitted to Local Boards.

TOTAL NUMBER OF CASES CONSIDERED.....877

Deferment Recommended.....578

Owners.....	239
Co-owners.....	44
Chain store asst. mgrs.....	38
Chain store mgrs.....	27
Clerks.....	215
Chain store clerks.....	7
Non-practicing pharmacists.....	8

No Deferment Recommended.....299

Owners.....	33
Co-owners.....	18
Chain store asst. mgrs.....	10
Chain store mgrs.....	5
Clerks.....	209
Chain store clerks.....	8
Non-practicing pharmacists.....	16

The Committee performed a noteworthy work and built a bridge of good will between Selective Service, its Local Boards, and the organized Pharmaceutical Associations. Our indebtedness to them is here acknowledged for their contribution to the war effort.

Hospital Advisory Committee Activity

The War Manpower Commission, Procurement and Assignment Service, had jurisdiction over the professional personnel of the hospitals but there was no specific agency extant to give expert advice on the essentiality or availability for military service of the technical staffs as well as the maintenance staffs of the city's hospitals.

The New York Association of Hospitals officials were intensely concerned that their hospital technical and maintenance staffs should not be depleted to an extent which would affect the efficiency of their institutions in the needed services for the civilian population. It was therefore determined to establish a Hospital Advisory Committee to make recommendations as to the essentiality or availability for military service of such hospital personnel whose classification status presented problems to Local Boards.

The Committee consisted of the following hospital executive officers (Superintendents), and of Dr. Edward M. Bernecker, the Commissioner of Hospitals of New York City:

Mr. Berger E. Foss

Dr. Joe R. Clemmons

Mr. John J. Kelly

Mr. William B. Seltzer

Mr. Bernard McDermott

116 cases were sent to this Committee through the Medical Division by Local Boards. Of these, 99 were recommended for deferment and in 17 cases no deferment was recommended.

Our appreciation for the work performed by this Committee is hereby expressed. It is true enough that more were deferred than were recommended for induction, yet the fact that this Committee represented the actually sick of the city's hospital population made such decisions warranted under the circumstances.

Salvage Of Manpower By Substantiation Of Positive Serologicals

On September 16, 1944, there was completed a study of registrants rejected and classified in IV-F because of positive serological tests made by means of the Kline test. The following is the report.

1. There is a provision of the New York City Sanitary Code which requires that cases of syphilis when found by a physician practicing in the city shall be reported to the New York City Department of Health. This provision was invoked to report to the New York City Department of Health the names of registrants who were found upon examination at the Armed Forces Induction Station to have two positive serological reactions to the Kline test.

2. It was, of course, realized that the Kline test was not definitely determining. In many cases an actual Wasserman test, either upon a blood specimen or a cerebrospinal fluid specimen, was necessary to clarify the registrants' status as to acceptability or to warrant positive rejection from military service.

3. The situation was altered somewhat after the Armed Forces changed their criteria for acceptance of the registrants who gave a positive serological test. After that time military hospital facilities to handle a percentage of these cases became available, and registrants with positive serological tests were tentatively accepted.

4. The control of the registrants with positive serological tests rejected by the Armed Forces Induction Station was made possible by the fine cooperation of the Bureau of Social Hygiene of the New York City Department of Health and its Social Hygiene Clinics throughout the city.

After conferences held between the Director of the Bureau of Social Hygiene and some of his staff and myself, a plan was evolved which, based upon the Sanitary Code on the one hand and on the cooperative efforts of the personnel of the Local Boards on the other hand, constituted a threefold program.

a) The Local Boards counselled the registrants voluntarily to report in person to the Social Hygiene Clinic nearest their homes for a recheck of their serology to verify or contradict the findings at the Armed Forces Induction Station examinations.

b) The Bureau of Social Hygiene placed one of its public health representatives at the Armed Forces Induction Station to "talk" to men rejected because of positive serological

findings and induce them to accept remedial therapy. This was further enhanced by the procedures instituted at the Social Hygiene Clinics. Wherever the Clinics substantiated the findings of the Armed Forces Induction Station, the personnel of the Clinic, in the registrant's behalf, stressed to him the need to accept therapy not only for the sake of his future health but because if treatment was accepted and taken, he, - the registrant, - might be resubmitted to the Induction Station and if he had no other disqualifying defects he might be enabled to have a classification other than IV-F.

It is to be noted that it is the medical profession's oft expressed opinion that were medical facilities placed at the very door step of our people there always would be some who would not accept the proffered aid. There were 4,637 who refused to cooperate and accept any therapy.

Because the Department of Health, under the New York City Sanitary Code, has control only of persons in the communicable stage of syphilis, there was no procedure either under the Health Department's Code or under the Selective Service System to induce these 4,637 registrants to accept the therapeutical help they so evidently needed.

c) The third endeavor comprised this Headquarters' concern over the question as to the possible manpower salvage that our plan would bring about. This was the paramount reason for our directing and supervising this activity.

5. In this report no purpose would be accomplished by detailing the steps in the procedures to effect the results that were our aim. Suffice to make record of the wholehearted cooperation of the 280 Local Boards of this city.

In this effort 6,624 registrants were brought to reexamination and those requiring and accepting it were brought under treatment. In addition, it was found that 4,325 undertook treatment in the various clinics of the city's hospitals and 923 came under the care of their own private physicians. To a large extent these figures constitute a group who otherwise might never have gone to the Board of Health, or to any hospital clinic, or to their private physician to get the medical care either they obviously needed or to have determinations made that proved they were not syphilitic.

It became evident at reexamination at the Department of Health's Clinics, after detailed examinations, that 4,155 actually were not syphilitic persons and as far as the question of syphilis was concerned, they were available for military duty.

6. The large number of registrants whose original serological reaction to the Kline test was positive and who, upon subsequent examination by more specific tests were proven to be non-syphilitic, needs a note of explanation.

The Kline test, the one used in the routine serological testing at both the Local Board and at the Induction Station examination, is too sensitive, and sometimes gives a positive result in persons not suffering from syphilis. The incidence in the patient's medical history of yaws, pinta, leprosy, malaria, and infectious mononucleosis among other conditions, vitiates the validity of the test for syphilis, unless these lesions have been ruled out definitely. Especially among itinerant Negroes, Mexicans, Portugese, and South and Central Americans is the application of the Kline test apt to be misleading.

An additional factor needs to be recorded. Among the 4,155 registrants who presented equivocal Kline tests, leaving the question of syphilitic involvement undetermined, the reexamination and specific tests by the Department of Health Clinics clarified their status. This number was found not to have the disease. This information was an intense mental relief to many of these registrants, and in some cases, to their parents who had come into this Headquarters much perturbed by having had their sons inform them of the reason for their failure to be accepted for military duty because of the finding of a positive Kline test.

Of the registrants who accepted treatment from their private physicians and at the various Out-Patient Departments of hospitals located in this city, many had not been receiving treatment before the Medical Division at this Headquarters started these procedures in its efforts at manpower salvage for military service.

7. Our compilations are in three categories. First, those under consideration from October, 1940 to August, 1941. In this group, in which no ages are on record, 548 were found

correctly disqualified. In the second category, viz., those 18 through 25 years of age, 752 were found correctly classified in IV-F; while in the older age group, - the third category, - 4,435 were found who were correctly classified in IV-F.

The whole number of those classified in IV-F for reasons other than syphilis is 5,735. These nevertheless had positive serological reactions. Their other disqualifying defects were of more significance than was the finding of a "truly positive" serology. These needed much more and additional therapy than treatment of their luetic condition.

The number with actual neurosyphilis in the registrants under review was relatively small, viz., 523. Among those in the age groups younger than 25, the incidence of neurosyphilis was very small, viz., only 24. These figures bear out our general experience with figures anent rejections in the New York City area as regards physical defects. The age groups from 18 through 25 years show less rejections than any other group.

8. This activity on the part of Selective Service and the New York City Department of Health in cooperation has resulted in the accomplishment of two objectives.

1) It has caused the reconsideration of classification of 4,925 registrants. In the figure 8,308 whose records show that they were inducted or enlisted, some of this group is undoubtedly included. It is impossible with the technical staff at my disposition to make a more accurate estimate of the manpower salvage attained.

2) It has brought under remedial anti-luetic therapy approximately 7,709 registrants. These figures are reached by adding those contacted for treatment, those that had the minimum treatment completed under the supervision of the Department of Health, and those under treatment by hospital clinics and privately practicing physicians.

Appreciation is expressed to Dr. Theodore Rosenthal, Director of the Bureau of Social Hygiene, and Mr. George Kirchener, Statistician of the Bureau of Social Hygiene, New York City Department of Health, not only for their fine cooperation in clarifying the undertermined cases, but also for the copies of their work-sheets, and other details which they furnished me to make this report possible.

Anent Student Deferment

The student body in the Colleges of Medicine, Dentistry, and Veterinary Medicine came under scrutiny and recommendations emanated from the Medical Division concerning their classification.

In the early days of Selective Service activities, many men who had been graduated with B.S. and B.A. degrees from colleges and who thus possessed the premedical or the predental scholastic requirements to qualify for admission to the professional schools, engaged in occupations having no relation whatsoever to either dentistry or medicine. They were carrying on business careers in many types of non-professional occupations. The war ensuing, and their disinclination to be selected by their Local Boards for military service, caused on the part of a number of these immediately to enter any medical or dental school which would accept them as students. The advice given to the Local Boards in regard to these was that they did not, in our opinion, warrant deferment. The exact numbers of such were not kept and exact figures of this group are not available.

For a considerable time, under the Regulations in force, the continuance of deferment for a given student was predicated upon the presumption that the student was progressing satisfactorily in his courses, and there was a reasonable chance of his graduation with the degree of M.D., DDS, or D.V.M. Hence, when any of the colleges sent notice of the failure of any student in his professional studies or failure of progressive advance with his class toward graduation, he lost his right to deferment. Where Local Boards requested opinion, no deferment was recommended for such.

Latterly, all these Regulations were superseded, and a document called a Form 42A (Special) was required to be submitted by the college for bona fide students below the age of 26 years, upon which the Medical Officer placed a recommendation for exemption from induction under the provisions of State Director Advice No. 255. For older students, a Form 42A was submitted to Local Boards and determinations made either at the Local Board level or at the Local Board after an opinion was expressed by the Medical Officer, either recommending or not recommending deferment.

Our files at the Medical Division give the following:

Deferment recommended.....	1047
No deferment recommended.....	131
No Action ⁹	16
TOTAL	1194

Since a new procedure is in vogue since April 1, 1945, which involves the use of the new Form 42A (Special-Revised) which needs no approval by State Headquarters, regarding the deferment of students this Headquarters has no further figures. These Forms now go directly to the Local Boards.

Studies Undertaken On Source Material

During the last year particularly there were many important questions discussed with various officers of National Headquarters. The views and opinions of the Medical Officer of New York City Headquarters were casually asked, and it was suggested that he forward a memorandum presenting his views for detailed study and consideration by Divisions of National Headquarters. Thus, on November 8, 1944 there was submitted a memorandum entitled "Proposals Anent Procurement of Manpower for the Armed Forces." This proposal contained suggestions for the handling of manpower in the event that universal military training is put into effect in peace times, as well as changes in the method of handling manpower which the experience of four years of Selective Service would seem to justify. A copy of this memorandum is appended.

The number of registrants rejected is a matter of deep concern. Even though the rejections are based upon a criterion or standard of physical and mental health based upon fitness and suitability for military service only, it is a challenge to the medical profession, in particular, and the community that future generations should show much improved conditions. This is of importance not only when a part of the community is measured by the standards which qualify for military service, but as a means for procuring for more individuals a fuller, healthier and better living level, and an occupational effectiveness. A memorandum entitled "Proposals Based on a Study of Rejections of Registrants in the New York City Area to Procure a better Health Level" was submitted to National Headquarters dated September 28, 1944. It is listed in the attached.

Another study, sponsored by me, was undertaken by Mr. Oscar Halper, the senior psychiatric social worker at that time attached to the Medical Division. This entailed "A Study in Psychiatric Cases Based Upon Examinations to Determine Fitness for Military Service of a Sample of 696 Cases from the New York City Selective Service Area." This study was completed September 15, 1944 and forwarded to National Selective Service Headquarters. It was subsequently published in War Medicine, Vol. 6, No. 6, December, 1944, under the title "Validity of Psychiatric Criteria for Rejection for Service with the Armed Forces. Study of the Cases of 696 Registrants with Psychiatric Diagnosis from the New York City Area."

To study the needs for rehabilitation of men rejected for, or discharged from the Armed Forces for neuropsychiatric disabilities, the Medical Division assisted the New York City Committee on Mental Hygiene of the State Charities Aid Association in the study. The Medical Officer joined the Advisory Committee on the study.

The Chairmen and the Clerks of ten Local Boards cooperated in providing source material. Local Boards Nos. 4, 50, 52, 57, 70, 78, 91, 136, 141, and 239 were selected so that they represented a range of distribution representing differences in incidence and type of neuropsychiatric disabilities. Six of these Boards had rates of rejection above the average, and three had rates below the average for the city. One of the Boards selected was concerned almost wholly with Negro registrants. Thanks for wholehearted cooperation is extended to the Chairmen and Clerks of these Boards.

This study, which will be published by the New York City Commmttee on Mental Hygiene of the State Charities Aid Association, has already shown some significant findings. The following is quoted from their report.

⁹ No action was necessary because of I-C or IV-F classifications.

"Socio-economic factors have a direct relationship to the proportion of neuropsychiatric rejectees. The more native white, the more home ownership, and the higher the rent paid in the population of a Local Board's registrants, the smaller is its proportion of examined men who are rejected, and the smaller its proportion of rejected men who have neuropsychiatric disabilities."

The examination of the known background data of neuropsychiatric rejectees and discharges, and other registrants from Selective Service Boards studied gives the following facts:

1. In most social characteristics, the neuropsychiatric group resembles the population as a whole.
2. Neuropsychiatric rejectees tend to be older than inductees.
3. Men with neuropsychiatric disabilities are apt to have had less than twelve years of schooling than men without such handicaps.
4. The neuropsychiatric rejectee and discharger are found in unskilled occupations more frequently than other men.
5. There was more unemployment previous to induction or rejection among the medically or psychiatrically unfit than among others.
6. Both neuropsychiatric rejectees and discharges asked for fewer deferments than did the non-neuropsychiatric group.
7. The proportion of married men was smaller in the neuropsychiatric groups than in the others.

The final report will be published by the New York City Committee on Mental Hygiene of the State Charities Aid Association.

The Medical Division published six Bulletins anent the causes for rejections in the early days of Selective Service Activity. These were Medical Bulletins #1 to #6 inclusive. Subsequently, National Headquarters published all further statistical data on causes for rejection.

The Purpose Of The Forms Noted In Text

DSS Form 200 - Report of Physical Examination (Discontinued 11/9/42)

DSS Form 221 - Report of Physical Examination and Induction

DSS Form 220 - List of Defects - for disqualification at the Local Board level (in use at present)

Local Board Release No. 66 - List of Defects for which a registrant could be disqualified at Local Board level. (In use from January, 1942 to August 15, 1942).

Medical Circular No. 4 - Outline of Medical Survey Program procedure

DSS Form 210 - Identity Verification card sent in by Local Board for clearance with regard to the Medical Survey Program

DSS Form 211 - Educational Verification card sent in by Local Board for clearance of registrant school record (Medical Survey Program)

DSS Form 212 - Medical and Social History - report to be filled out by Medical Field Agent (Medical Survey Program)

DSS Form 212-A - Envelope for Form 212

DSS Form 213 - Cooperative School Report form sent out by this Headquarters for registrants on whom schools have not sent in report (Medical Survey Program)

DSS Form 214 - Special School Report

MR 1-9 - War Department Standards of Physical Examination During Mobilization

C.D.D. - Certification of Disability Discharge

Form 42A (Special) - Affidavit - Occupational Classification - for registrants under 26 years of age.

Form 42A (Special-Revised) - Affidavit - Occupational Classification - for registrants under
· 30 years of age.

State Director Advice No. 255 - State Director's Recommendation for occupational classification
of registrants 18 through 25, other than agricultural.

REPORT ON PROPOSALS BASED ON A STUDY OF REJECTIONS OF
REGISTRANTS IN THE NEW YORK CITY AREA
TO PROCURE A BETTER HEALTH LEVEL

September 28, 1944

The major causes for rejection because of physical defects may be divided into the following four categories:

- I. Developmental defects such as congenital deformities, mental deficiencies, and defective vision.
- II. Neglect - failure to employ available medical aid, resulting in chronically discharging ears, underweight, insufficient and ulcerated teeth and other mouth conditions.
- III. Traumatic causes, the result either of athletics, types of employment, or of automobile accidents, which resulted in hernias, flat feet, enlarged but not diseased hearts, or lung conditions due to the inhalation of sand dust (silicosis).
- IV. Diseases as yet not conquered by medicine, such as rheumatic fever, valvular heart disease, essential hypertension, and the results of infantile paralysis and pulmonary tuberculosis.

A number of general observations are pertinent. The war came upon us just after about a decade of economic and mental stress due to the overall economic situation with its concomitant large unemployment problem and with the economic level of large numbers of our people lowered due to the prevailing economic depression.

Underweight, malnutrition, and neglect to avail themselves of medical facilities which are ample in the New York City area accounts for some of the findings.

It must be remembered that low wages, and bad housing are intimately interwoven in the problem. The provision of more medical facilities in this community would hardly change the picture. Better living quarters, full time employment, and a higher wage scale, coupled with a continuing and persistent educational campaign would do more to lessen and perhaps obviate a number of physical defects found than any increase in general medical facilities in this community.

There is very little medical evidence in this group to show that acute illnesses have left permanent bad after-effects upon these individuals due to an absence of medical care during the acute illness. Summarizing the entire study of those accepted for military duty, including those accepted for or designated for limited service only, one may conclude, after surveying the divers causes for rejection, that the health of the city's population is good.

We should not be satisfied, however, with the present level of health. It should and can be bettered.

Leaving out of account that an improved economic level with better living quarters, more and varied foods, and generally improved sanitary and hygienic conditions which would ensue therefrom, nevertheless, a general health program should be the first step in a campaign of prevention, so that in future times similar figures of rejection would not be found in our population.

This should be instituted not only for its value to produce a larger number of men fit for any subsequent military service, but also for its effects in peace time, to produce healthy industrial workers, and in fact a better health for future generations.

The Health Level Of The Adult Is
Predicated Upon Children's Health

It is known to students of the problem that one can predict the health of the man from the medical findings among the childhood of the nation. I say this, among other things, on the basis of the Hagerstown, Maryland, study.

Unfortunately, only in rare instances are consecutive and continuing childhood health studies carried on and medical records kept continuously on the individual infant and child and carried along with him through school and college career, or where he enters industry from his school days, brought to the medical departments of the larger industrial plants and larger selling organizations which he then joins.

The School Physician

In the schools in most of the areas of this state, a physician is in attendance. His present duties are mostly concerned with contagious disease quarantine. He separates contacts with contagious diseases from the school's population.

In this city his duties are mostly concerned with the same item.¹⁰ In many schools there is also a graduate trained nurse on duty. Primarily, she has the functions of a public health nurse and does little more than advise parents of children found undernourished or apparently deafened or apparently with lessened visual acuity, or she renders first aid and advice to the school children who happen to become ill while at school. In other words, she handles the obvious medical problems which are brought to her. She has no function to initiate or carry out public health and physical health education in the school except in a most desultory manner.

In my opinion, the school physician should have a full time job. He should actually be a medical school officer. He should start and keep a continuous and continuing record of a series of complete physical examinations of the school's population, which is under his care. It should be his duty to see that records and all methods of prophylactic immunization in all established categories are carried out either by the child's private physician or himself. His office should be at the school and he should be supplied with a adequate staff.

The school physician's medical staff should contain, along with the necessary technical laboratory help, a trained nurse and dietitian, a dentist, an expert on problems concerned with behaviorism (either a psychiatrist or a psychologist), and a physical training expert. The very names of these medical staff associates connote the type of duties falling within the scope of their activities.

In the special schools, such as the School for the Deaf, either the school's medical officer should be a qualified otologist or such a qualified individual should be on the school's medical officer's staff.

This staff should be obligated to both examine each in his proper domain and also treat such cases among the school's population as were found not to have a private physician and who, in their professional opinion, require the correction of minor defects which are remediable.

Thus, teeth could be conserved, cavities discovered when small, maladjusted behavior problems handled, and programs for general physical training carried out in full cooperation with the educational departments. In the matter of physical training, the adjustment of such to the capacity of physically handicapped children would entail cooperative planning by the school medical officer and the physical trainer.

The larger number of rejections for various types and degrees of psychiatric disabilities makes it necessary to begin the adjustment of the maladjusted child as early as possible and thus stop the further enhancement of anti-social and unpredictable behavior and the emotional instability found in the young adult.

Where major medical conditions are discovered, liaison with the parents, the family physician, or where it is discovered that the family is unable to provide such, with the public or voluntary hospital serving the neighborhood should be undertaken to provide remedial therapy.

The educational campaign carried out in the school, not only among the school population but aimed also at the Parents' and Teachers' Associations, should stress the dogma

¹⁰Since writing the above, I have been informed that in the whole City of New York, about 6 High Schools, mostly vocational, actually have a medical school physician who does more than the work outlined in the text. It still is not the type of service that I would envisage to cover the type of medical supervision which I believe required for the school aged population.

that no member of the community has an inherent right to remain unfit physically or mentally, while the community has ample facilities, and Medicine, the means and methods to correct the deficiency.

There is nothing of such paramount importance to the state as the health of its citizens.

Since the health of the adult is, in most instances, predicated upon the health of the community's children, the goal of still better health of the community is reachable by remedial therapy rendered when the disabilities are just becoming apparent.

In regard to the deviations from the normal, both physical and mental, discussion and study of available records demonstrates that some of the mental deviations from what is considered normal become apparent at the earliest school age.

Preliminary discussions with competent school authorities reveal, in a very casual survey of the material on file, that correction of these behavior deviations needs attention from two angles: (1) correction of possibly existing rigidity of primary school curricula; and (2) psychiatric direction in leading back toward normal behavior the child whose conduct denotes a trend toward abnormality.

On this aspect of the problem concerned with the attainment of a better health and physical fitness level, statistical material is on file in various agencies dealing with child guidance. Under the auspices of the National Joint Committee on Physical Fitness and Health, further studies are under way, and the general acceptance of improved criteria for establishing determinations in estimating deviations will undoubtedly be evolved. Subsequently these, coupled with the indicated amendments to rigid school curricula, will provide another step toward the goal aimed at; viz., better health and better fitness.

Our records of rejections have shown that the lower the age group studied the less the defects found per thousand in the population. The older the age group studied the larger the number of defects which a given individual shows, and the greater the gravity of some of them.

The Medical History

The medical history of the school child should follow his educational phases. It should go to the grammar school, then to the high school, and to the college if he elects to take a college career. If, on the other hand, he enters business or industry this medical history should be made available to the medical officer of the business or plant where the individual begins work.

Medical Departments In Industry

Industry changes also are needed to attain a better level of general health. There should be a medical officer on full time duty in each plant. A nurse also should be on duty at each plant, and particularly there should be a qualified psychiatrist or psychologist. A dentist, too, should be established in each plant.

The duties of this medical department, in addition to rendering such medical aid and assistance as may be necessary for those who are unable to pay for it, should be to teach medical hygiene and observe and study the industrial health hazards to which the worker is exposed, as regards the particular plant where he is employed. The medical officer of the plant should recommend such changes as may lessen industrial health hazards. Records of periodic complete physical examinations should be kept, and minor defects, as soon as discovered, should be brought into contact with facilities for remedial therapy.

The psychiatrist at such a plant has an important job. The maladjusted workman who cannot adequately function in the group of his fellows eventually deteriorates and gradually goes on the downgrade for quite a length of time, until eventually he becomes an unemployable. These unemployables are a serious problem in the community. Anything which lessens their number adds to a better living level of their dependents and consequently also to a better health level in the community where these dependents and they themselves live.

With a health record and the history from the elementary school until the time the youth goes to work, the medical officer of the plant will have a better idea as to the

workman's "useability" and also he will have a knowledge of his acquired physical handicaps. His assignment to specific work obviously should be such as not to increase this physical handicap.

The tendency of organized labor not to permit a physical examination at the time a workman is hired is based upon false thinking. The disclosure to employers of a physical handicap does not, and should not preclude hiring, but it will lessen the awards for industrial accidents and thus save taxpayers' money. It should not in any way prejudice a just claim for injuries incurred in industry any more than a physical examination of a recruit accepted under a waiver for some minor physical defect noted at the time of his examination prejudices his compensation or pension when he is honorably discharged from service after a disability incurred in the service.

Physical vs Health Levels

In some states preliminary steps along these lines have already begun. The matter lags because of the undue stress on muscular development. Physical training has become enhanced. Muscular development and muscular strength developed by exercise is not necessarily synonymous with health.

Our studies of the rejected registrants have given us too many athletes who were found physically and mentally unfit for military duty. Some of these became problem cases because of their place in the public eye due to their athletic prowess in some particular sports field.

Need For A Centralized Agency On National Level

The program halts also because there is no central coordinating authority to embrace the entire national overall coverage of national health. As a matter of fact, it is almost impossible to locate sections of bureaus and departments scattered in various government agencies in Washington. The U. S. Public Health Service is in the Federal Security Agency. The Children's Bureau is in the U. S. Department of Labor. Many other instances might be cited.

The medical profession has long been cognizant of this situation and have upon various occasions advocated a Cabinet Officer heading a national department concerned with all matters pertaining to the health of the people. In this Cabinet department each and every bureau and subdivision which deals with health questions should be assembled and their particular work reviewed. If they are in the process of performing a worthwhile service, that should be continued. The U. S. Public Health Service, now under the Federal Security Agency, is actually perhaps the largest and best known health agency of the national government. In the future, with the natural contracture of the world's surface because of aviation, and the interchange of people from the tropics to our temperate zone, a great intensity of vigilance will fall on this agency to protect us from the insidious tropical diseases heretofore found only in the more remote quarters of the world.

This agency should not be concerned with planning, maintaining, or providing for hospitals in the community as some are now proposing. A section of the proposed Federal Department of Health should have this obligation.

The Federal Government and its agencies are considerably handicapped under existing conditions when they have problems dealing with health and physical fitness. They find themselves almost invariably forced to handle the given problem not with a duly qualified person of top rank in a governmental department, or a Cabinet Officer, but with some subordinate, often on a secondary or subdivisional level of a government agency. The top executive of this agency is primarily concerned with matters totally devoid of any connotations with either health or physical fitness problems. This is true even in sections and divisions of the governmental department concerned with education. There is no divisional department head in charge of health and physical problems which would naturally come under the consideration of those concerned with education as it affects health and physical education. I cite this as only one example of an urgently needed change.

For another example, the Federal Government, by and large, because of the absence in its set-up as regards medical questions generally, in other words, a medical man of Cabinet rank, deals mostly with the United States Public Health Service. It is assumed that this department of the Federal Security Agency is competent "to speak" for Medicine generally. This is so evidently a fallacy that it often results in proposals becoming broadly publicized before the consensus of competent medical opinion is obtained, or, for that matter, even a discussion or a thinking through by competent medical men on a given problem is even started.

The organized medical profession is a democratically constituted organization reaching down into every county of the country below the State level, and all reputable practitioners hold membership in it, or they can if they desire to. The officers and Board of Trustees of the American Medical Association can only express the opinions of the entire profession as formulated, considered, and acted upon. They have established sections in every special branch of medicine, and have facilities and means to carry on any specific studies desired.

The Federal Government should more fully avail itself of the opinions and facilities of this organization whenever an expert opinion on a given problem is wanted. The average general medical man's opinion is that the U.S.P.H.S. is gradually endeavoring to intrude itself into the practice of medicine generally, rather than keep to its public health functions. That this is not necessarily true, does not mitigate the generally held opinion among the country's practitioners of medicine.

In this outline the definition and limitation of scope of the U.S.P.H.S. is not necessary. I am only outlining the difficulties encountered in setting up proposals to reach a better health level for our people, and underlining two outstanding examples of the necessity for a medical man of Cabinet rank to head this division and make the necessary coordinations and reorganizations to attain that result.

The State And Local Agency

Because a Federal Cabinet Office is suggested is no reason to presuppose that states rights are to be over-ridden. In carrying out all projects which reach State level these should be handled at State levels by State officials. The Cabinet Officer concerned with health problems coordinates, initiates, and stresses to the State set-up the goal in view in each particular instance. Carrying out of the necessary procedures falls under the states' authority and jurisdiction. In many instances it must be carried out by local community efforts even below the state level.

The Executive Council

The proposed Cabinet Officer should have an Executive Council to serve him as experts.

On such a Council the Surgeon Generals of our Armed Forces, as well as the Surgeon General of the U.S. Public Health Service should serve. Additionally, there should be representatives of the academic branches of scientific medicine, each representing its specific specialty on this Executive Council; for example, the American Academy of Otology and Rhinology, the American Heart Association, the American Academy of Orthopedic Surgery, the American Academy of Radiology, the American College of Surgeons, the American Neurologic Association, the American Association of Plastic Surgeons, etc., etc., and to represent the general medical profession at large, a representative of the American Medical Association.

Medical teaching should be represented by a representative of the American Association of Medical Colleges. The dental profession, the nursing profession, and the social service agencies should also be represented. Likewise, an Association of Scholars interested in research problems should be represented.

Research

Our public is amazed at the medical advances made during the war. It is a sad commentary that the most wasteful, destructive thing that man has devised, namely, war, should be the background from which these advances emanate.

Perhaps under the emotional stress of war man may be and is forced to think significantly and produce thoughts which, carried over into peace time, would be helpful to the

situation and prolong human life. In peace time, thinking and research to conquer diseases and conditions as yet beyond therapeutical help should be nationally supported. A division of the proposed Federal Department of Health should be obligated to carry out this function.

The Council suggested need not meet too often. It should be allowed to delegate its authority to an executive group which it would elect.

Were such a Cabinet Officer in being at the present time and the highest quality of the medical profession's opinion voiced by this officer, then the public educational campaign to carry out the necessary evolutionary changes to acquire a better health level of our people would be focussed and significantly pointed. The spokesman for medical opinion should have the necessary prestige to impress everyone concerned.

Like the Army and the Navy, this Cabinet position and its Council and its departments should be entirely apart and severed from all political activities. It should serve the nation, and have no political party affiliations. Its function is national health, which never should be a political question at any time.

Proposal Is Not Socialized Medicine

It will be claimed that this is socialized medicine. It is neither socialized medicine nor prepaid medicine nor compulsory medical insurance. Most preventive and prophylactic measures are not community concerns, and are handled by local Health Departments. No one considers these socialized medicine in the form to which, by and large, the medical profession objects. In the proposed set-up, wherever any of its projects to render therapy to individuals can be paid for, no government should intervene to pay the costs; but no citizen should continue to have inferior health because of inability to personally finance his recovery or his improvement in health, because health is not an individual's problem. As shown above, one workman's lowered health level affects his whole family and when "one" is multiplied by "many," the community is affected. On the other hand, sickness affects individuals who must seek recovery. This they can procure from privately practicing physicians and at the hospital facilities in their community.

Voluntary Pre-Paid Medical Care

In the ensuing post-war period we should see a further great development of the voluntary pre-paid hospitalization plans, and continuing educational campaigns should be encouraged to further the development of such plans.

In industrial plants and large selling organizations the medical departments should be integrated into the pre-paid hospitalization plans and freely employ the available hospital facilities in the community in which they are located.

The one great obstacle to an even level of medical service in this country is the political obstacle which Federal grants in aid entail. Sections of our country are richer in medical facilities than are others. If the overall authority desires to grant medical facilities to the states which are too financially handicapped to provide them, then it usually happens that the money is voted on a population-pro-rata basis. The richer communities thus having much get more. Actually they may not need any more.

It should become political dogma that funds should be given for specific facilities and not on a population-pro-rata basis. Here, too, the citizens' better comprehension of the factors at issue will not result in reactions harmful to the political career of those members of Congress who voted help to the less rich states and none to the richer ones, so as to improve specific facilities to procure better health levels of the people and equalize the level of medical facilities throughout the country.

Diagnostic Facilities

The proposal to establish diagnostic laboratories and consultant services to the communities which are poor in these resources is a step in the right direction. The handicap which the pending proposal carries is that it seems to the profession as if this is to be a Board of Health job locally, or one under the U.S. Public Health Service. I think the proposal is excellent, but it should be, since it is a new project about to be started, set up in an overall framework of the proposed Federal Department of Health.

Health Level Of Negroes Needs Improvement

The larger number of physical defects and deficiencies among the negroes as compared to the whites is a matter of grave concern. Basically, it rests upon the fact that there are too few Grade A medical schools, training schools for negro nurses, and social worker training centers for negroes, in existence.

The problem can be handled in one or two ways, or a combination of them. Since these citizens' health is as much a concern of the state as that of any other element of our population, either all Grade A medical schools, nurses training schools, etc., should be induced to accept a set quota of negroes in the regular college classes or separate schools should be set up for such to supply medical facilities for our negro citizens. In those states which local adverse public opinion against a mixture of the white and negro races, in such colleges the separate school should be the planned procedure.

November 13, 1944

The proposals concerned with the procurement of manpower for the Armed Forces take on many pertinent aspects. Necessarily it presents an entirely different facet in peace than it does under the stress and hurry incidental to war time expansions to meet the inherent needs of the situation as determined by the General Staff.

From the experience which the country has had both in World War I and the present conflict, it may be premitted to recommend changes which, in the writer's opinion, might not only make the selection of manpower more efficient, but also effect changes in the assignment of recruits to service units. Finally, by adopting the proposed changes it would be possible to salvage what seems a degree of wastage of manpower under the present system.

Making this report, it is assumed that as a result of the situation in which our country found itself in 1940 some form of military service will be enacted. I prefer to hope this will take the form of a universal military service law for all youths between the ages of 18 and 21.

Universal Military Service

It is presumed that our public and our legislators will have learned the bitter lesson that a nation unprepared militarily for war does not prevent wars from engulfing even a sincerely peace-minded nation. Likewise, with the inevitable contracture of the earth's surface because of aviation, no nation any more can rely on bordering oceans as a means of protection against aggressive assault. Further developments of the so-called Robot Bomb, and its successors, whatever they turn out to be, will only add strength to this argument.

Military training in peace time is therefore a proper concern at this time while the war time experiences are still fresh in mind. Military training has great advantages for our youth. Among other things to be noted is that it inculcates discipline and character building into our youth, at their most adaptable age. The forces it would provide to study the physical status and health of our youth cannot be overemphasized. The opportunity to therapeutically remedy minor physical and mental deficiencies before they become grave and serious would tend toward a better health level in our population.¹¹

The great chance that the assembly of our young men in a military community gives to have racial groups learn to comprehend one another, and become America conscious in lieu of race and class conscious, is something which is a desired intangible absolutely necessary in the further progress and development of a really democratic country. General military training would give all our youth a patriotic focus upon our country, lessen local community prejudices, and tend toward the attainment of a better citizenry.

During military training many crafts and skills are taught. General military training will bring such crafts and skills to many youths who have natural aptitudes toward them. In such, the stimulus of the militarily taught crafts and skills will incite their intellectual curiosity in many instances to perfect themselves subsequently in one or other of such crafts and skills. Thus, for large numbers the opportunity which military training gives will open doors which they otherwise would hardly even approach.

The literacy level of the country is very uneven. From some sections of the country youths do not read or write our language. During World War I, after the Armistice, I started my officers teaching reading and writing to the illiterate enlisted personnel. Illiteracy should not prevent acceptance for duty in the peace time army. Part of the military training period should be utilized to remove the illiteracy. The benefits from this to the individual and the community are obvious.

Lastly, general military training would remove from the civilian community boys at the very age where, in many instances, they become community problems due to juvenile delinquency.

In New York City between 3,200 and 3,500 youths reach their 18th birthday every month. This should be the age at which they should be obligated to give at least one year of military service. I would also recommend that between the ages of 18 and 21 years, the youth have the option to select the year. Some youths are too immature at 18 years to profit by the training, a fact that must be kept in mind.

¹¹ 59 men in every thousand in age groups 18 to 21 years rejected could be salvaged by remedial therapy had these determinations been made during peace time and provision made to use remedial therapy to improve the physical health of these young people

What I have in mind in making the above recommendations is to utilize for military training the period between the termination of high school education, and the commencement of college training, or the beginning of his selected working career if college education is not what the youth will undertake.

The military training as I envisage it should be universal, with no exceptions. Even those physically handicapped can be utilized, and at least given training in discipline, character-building, and taught some military craftsmanship or skill.¹²

Nor would I grant exemption to medical or other professional students. These too would profit from military training. The man who had dedicated himself to a medical, dental, or engineering career, should be trained in the enlisted personnel of these departments of the armed forces. True, it may prolong his professional training an additional year, but on the other hand he gains something in intangibles and in maturity which will more than compensate for the time spent in military training. What he learns, for example, while serving under military doctors, or military engineers in various engineering categories, will enhance his interest in the profession he has elected for his life's work. On the other hand it may serve to demonstrate to him that the respective profession he has selected for himself, knowing now from actual contact with it, that he finds himself unsuitable for it, and that it is not what he conceived it to be, and actually he can decide on the basis of experience that he does not want to undertake it as his life's work.

In conclusion, the country would not only benefit from the insurance to its safety implied by its providing itself with the nucleus of an armed force capable of expansion to the degree necessary to meet national emergencies, but it would provide opportunity for many types of tests concerned with the proper selection and assignment of manpower for the armed forces. Likewise it would open the way for properly selected youths to enter and make military careers their life's work.

Recruitment Of Manpower

In the set-up of the personnel, and the procedures, certain general considerations need study now.

I believe there would be a great advantage in complete separation of all questions involved in socio-economic problems and the questions as to the physical and personality estimations to determine acceptability for military service. These are two separate and distinct preliminary processes which should not be interlocked.

Procedures In Peace time

There is little need for the elaborate Local Board procedures in vogue in wartime for use during peace. If a universal military service law is enacted, in the peace time procedure there would be, in New York City, a need for only one central office for each of the five Boroughs of the City of New York. At this office the youths should be interviewed, the forms filled out, medical certificates presented by private physicians recorded and evaluated, and any other preliminary procedures carried out as might be in the regulations.

Here the school history, DSS Form 213, and the DSS Form 212 should all be sealed together and attached to the Form 221 and sent to the Station where the physical examination takes place. The individual is then forwarded on his own recognizance to a training and examination center.

At this training and assignment center the complete detailed physical examination, including psychiatric and profile estimation, is to be made, inquiry and tests as to aptitudes and all other procedures to estimate the prospective recruit as an individual, carried out.

Since in my conception of universal military training all youths reaching their 18th birthday, or soon thereafter, shall undergo training, the criteria at the examining post should be a very much liberalized standard for acceptance during peace time. Some training should be given to all, so arranged that it will not enhance any physical disability which is found to exist upon medical examination. This is somewhat a new idea but if the reader will refer to

¹² The details as to how physically handicapped individuals are to be handled is outlined in another section of a report, not included herewith.

the section of this report on universal military training and note the advantages accruing to the youth if the Federal Government adopted the procedures suggested therein, citizenship, responsibility, and trades and skills, should be given to youths with such minor disabilities as, under the regulations in force at one time would have put them in what was then designated as I-A-L.

Wartime Procedures Need Improved Techniques

The present method of assigning recruits to military units leaves much to be desired. They go to the Reception Center, are processed as to necessary immunological procedures, uniformed, and equipped. They have interviews as to aptitudes and, more recently, are surveyed from the physical standpoint according to the so-called Profile Procedure. They then are assigned to units of the armed forces for training.

There is little chance in the present procedure to find a man thus assigned transferred to a different type of unit because he failed to make good in the place of first assignment without having to send him through hospitals and other cumbersome procedures which eventually result in his discharge from the service.

The men are put, for the most part, in a general pool and are assigned to units upon requisition for needed men to fill replacements, or for additional manpower because the unit is below its requirements under the Tables of Organization.

Too often such men are assigned without regard to their prior occupational trades or skills. Even the aptitude tests by which they demonstrate their abilities are disregarded. Their desire for a given service because they believe themselves fitted for it is also mostly disregarded. This feature of the program of recruiting for the armed service is not in the best interests of all concerned. The following proposals are suggested as providing improvements.

1. That the physical examining, classification, and training centers are to be established as separate units, constituting the lowest echelon of a separate command, under the control, supervision, and command of a general officer serving under the Chief of Staff, similarly as the Chief of Artillery, or Cavalry, or of the Air Corps serves. This separate command is to have all the necessary subordinate echelons down to the Commanding Officer of the examining, classification, assignment, and basic training units. The basic training unit is to be the first military installation at which the recruit appears for service.

In war time the following changes in the present set-up of such a service are recommended:

In contrast to the draft law of World War I, a step in the right direction was made when the medical examination was separated from all other activities of the Local Boards. In World War I, the Local Board physician was a member of the Local Board. In this war, the Local Board physician was not a member of the Board. His separation was a distinct improvement over the World War I procedure. So therefore, the following might be a continuation of improved procedures, predicated upon the same philosophy which resulted in the improved situation just mentioned.

2. Complete separation of the medical examination of recruits for the armed forces, including registrants who are selected by Local Board machinery to be inducted, from all questions of social economic employment and essentiality in civilian occupation. These questions should be the prime concern of Selective Service, and the machinery of Selective Service should function entirely apart from any question of physical fitness, or with service in the armed forces. Selective Service should be concerned only with the selection of an individual on the basis of his socio-economic and occupational availability.

3. The recruit, or selectee, having been found to meet the requirements of availability by the Local Boards should be sent directly to the Reception Center to be examined, processed, and outfitted, and should then be sent to units for basic training, and eventually for assignment to duty with troops. He should not be sent to specified divisions, or units either of garrison or combat troops, but kept during the entire period of basic training in a training unit, under the command of officers specifically selected for service with the various echelons of the training command. The Reception Center should include Army training battalions. For the Navy, there should be Navy training units. These units are to be entirely separate and apart from any combat, or general troops, or active Navy units.

During the stay of the new recruit in the training battalions he is to receive basic training and is to be under the observation of aptitude experts, and Army technical personnel, and competent medical officers, who evaluate the man and his capacities for various types of military duty. They determine, while he is in these battalions, whether he rates as capable of duty in the Air Force, or in the Ground Forces, or whether he will do better in Ground Combat Forces, or in garrison duty. They decide whether or not he has aptitude, and both physical and mental qualifications capable of acquiring higher technical skills; also whether or not he has the characteristics to be considered officer material.

In the determinations made during the period of basic training the Medical Officer assigned to the training center should take part in both the study of the men and have a voice in the recommendations as to their assignment to specific units, based on their mental and physical status.

Having been studied during the period of the basic training program which, as far as possible, should be common to all soldiers and sailors, the assignment to service is made, and the recruit joins his assigned unit not as a raw recruit but as a trained addition to the company with which his future military career will be concerned.

The present type of medical examination, which is predicated upon a list of physical and mental criteria as set forth in MR 1-9, can never be made to evaluate the finer distinctions which would be possible under the suggested period of medical and psychiatric observation. For example, two men from an entirely different level of civilian life both easily pass the MR 1-9 test, yet one may have inherent weaknesses in some particular, not determinable by either physical or mental examinations under the criteria as set forth in MR 1-9. The difference would be apparent during the training period, and with the advice and recommendation of an alert Medical Officer the assignment to duty with troops would be so set that both would be used in the armed forces at their highest physical and mental capacity, and with only a minimum chance of a physical or mental breakdown during the subsequent period of advanced training with the field units to which they eventually were assigned.

4. When and if a soldier or sailor, after reaching the assigned unit, is found physically or mentally unfit to continue with such unit, instead of hospitalizing him for a CDD with various diagnoses such as inaptitude, maladjustment, etc., the Commanding Officer of his unit should declare him unfit physically or mentally for further duty with his unit to which he was assigned. He should not be discharged from the service but sent back to the training unit from which he came for another assignment more within his mental and physical capacity as would be shown on the report of his prior Commanding Officer when returning him to the training battalion for re-assignment.

Much manpower for the armed forces would be salvaged by the outlined procedure and there would be fewer pension rolls for men discharged under a CDD who never saw battle-front duty and some not even garrison duty.

Finally, those injured during maneuvers, if after hospitalization it is thought they still have a degree of physical handicaps due to injuries incurred in the line of duty, before they are discharged and during the period of the war, should be sent back to the training centers from which they originated for re-assignment in some unit where they, as veterans of battles or maneuvers, may be useful either as instructors or for the sake of moral building among the newer recruits.

Finally, records in regard to personality, physical and mental examinations, DSS Forms 212 and 213 all are available at the Reception Center from whence the man came. Subsequently, when returned to the Center because of unsuitability for the unit to which he was assigned, judgments could be made based upon these records which are available to the Medical Officers concerned with his reassignment. If it is at all possible, the man should be assigned to another unit. In the event that no place can be found where he is suitable for duty, then only his discharge from service should be in order.

The proposed plan entails changes in set-up from the General Staff down to the local recruiting Service Command. If such a recruiting and manpower procurement service were established during peace, it would provide an excellent experimental situation for the training both of Medical Officers and Line and Staff personnel in the work of recruiting and assignment. Such a unit and Command would naturally carry on continuing studies to evolve improvements,

particularly in the realm of assignment. In the end, the officer staff would become experts in the questions concerned with procurement, selection, and assignment of manpower for the armed forces.

In the event of war, this trained staff would be the cadre from which the necessary expansions would result to meet the needs of the services, under the war conditions as they would be determined by the General Staff.

